State Registrar

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1009 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND TIEM/26, per HIYS. (872.10/16/07 WS State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death October 11,2007 **Physician** Frances Loretta Koermer /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** Baltimore 1514 Williams Street Essex 8. Date of Birth (Month, Day, Year)

March 14,1922 West Virginia 5. Social Security Number If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 ☐ F 215-18-0701 Director 85 March Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits items 23a or 28a-f shov iner must be notified at Baltimore MD 1 □Yes 2 XNo Director Glen Arm 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11907 Manor Road Be Completed by Funeral 21057 USA 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ▼No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 11. Marital Status r than "natural", or iten the Medical Examiner 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💆 No White Specify: 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Sun Life f Health and Mental Hygiene. item 27 is marked other than other traumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) Administration 12 Insurance 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Leon White Ida P. Glover 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any Injury or other trau
once. Richard May-cousin 1611 Sparks Road-Sparks, Maryland 21152 20b. Place of Disposition (Name of cemetery crematory or other place)
Sacred Heart Of
Jesus 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Oct. 15, 2007 Dundalk, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 8800 Harford Road Parkville,MD 21234 EVANS FUNERAL CHAPEL AND CREMATION SERVICES 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CONGESTIVE **Physician** /Medical HYPERTENSION

Due to (or as a consequence of): **Examiner** Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner and or Attending Physician: The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Month Dav Year 5 ☐ Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Nnknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 1□ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Sesidence 6 Nother (Specify) Cousin's 2 ER/Outpatient 3 DOA 1 Inpatient Certification: To After thi funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 5 Pending investigation s after death.

Il Director: Ai
d in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a

To the Funeral C

completely filled i To the Hospital Medical 29a Certifier Excertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) $\mathcal{F}_{\mathcal{D}}$ 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1838 breenetre 31. Date filed (Month, Day, Year) 32. Registrar's Signature State OCT 1 6 2007 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Kiesling Karl 10 0351 /Medical 4a. Facility Name (If not institution, give street and number) 4b/City, Town, or Location of Death County of Death 4c. Examiner Klin Square 1-650179 8. Date of Birth (Month, Day, Year) Oct. 10, 1918 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 1 M 2 □ F Hours Months Days Maryland 216-03-0382 Director 89 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show Examiner must be notifled at Middle River Baltimore MD 1 ☐ Yes 2 ☐No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō USA 21220 23a 3503 Beach Road Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? ↑ Yes 2 □ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 □ Never Married 2 □ Married ò 1 ☐ Yes 2 No Specify: White Specify: à 3X Widowed 4 □ Divorced Year or Dates: 'natural", Completed permit. Pages 1 and 2 should be filed within 72 hc Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any Injury or other traumatic event, the Medical i once. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Western Electric Mechanic 8th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Katherine Horn Herman Kiesling မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3503 Beach Road Baltimore MD 21220 Karl G. Kiesling /son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Holly Hill Cemetery 10/17/07 Baltimore MD 4 Donation 5 Dother (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licenses 300 Mace Ave. Balto. MD Connelly Funeral Home of Essex 21221 23a. Part1. Enter the disease, of shock, or heart failure. List plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, y one cause on each line. Immediate Cause (Final neum onia **Physician** disease or condition resulting in death) /Medical Due to (or as a onsequence of) Examiner Sequentially list conditions, Due to (or as a consequence of) Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed physician ar Due to (or as a consequence of): Physician/Medical attending p as IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 2 Fetal death 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 5 Other (specify) by the a 9 🗆 Unknown signed by it Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? à 1 ☐ Yes No 3 ☐ Probably 4 ☐ Unknown Completed peen 24a. Was an 24b. Were autopsy findings available prior to completion of cause of has e 2 autopsy performe page, death? certificate 2□ No director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 20 No Inpatient ပ 1 🗌 Yes 2 ER/Outpatient 3 DOA this 28a. Date of Injury 28b. Time of 27 Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: After 5 Pending investigation (Month, Day Year) Injury 1. Natural death. 1 ☐ Yes 2 ☐ No 2 Accident after death.

Director: / 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined

Box 68760, P.0. Division or Vital Records,

within 24 hours aft

To the Funeral D

completely filled in 6

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29a. Certifier

(Check only one)

31. Date filed (Month)

29b. Signature and title of tertifier

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30. Name and address of person who o

Day, Y(a) T 1 6 2007

eath (Item 23a) (Type, Print)

1900

Registrar's Signature

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 33004 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year Day 54 PM 10 2 07 Roy W. Kincaid Sr. 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore Rosedale FRANKLIN SQUARE HOSPITAL center If Under 1 Year | If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Months Hours 1 3M 2 F Feb.14,1928 West Virginia 233-42-2014 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 1X Yes 2 No MD Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3425 Leverton Avenue 21224 USA 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 Tes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b, Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Maintanance City of Baltimore 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John E. Kincaid Effie Wright 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Brenda Schmidt /daughter 112 Northwind Road Bear DE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 10/18/07 Bayview Crematory Baltimore MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 300 Mace Ave. Balto. MD 21. Sign Ture of Mineral Ser Kelix Connelly Funeral Home of Essex 21221 23a. Part1. Enter the disease, perhiplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List of ly one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Thmia FaTaL ARTERY b. AThe RoscleroTic CORONARY Se juentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (b) as a consequence of) HyperTension Due to (or as a consequence of): Diabetes IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 hknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 ☐ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 | Inpatient 2 | PR/Outpatient 3 | DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 Natura! 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29c. License number 29b. Signature and title of certifier

Examiner Box 68760, P.0. Division or Vital Records, the Hospital or Attending Physician: To the Hospital or Attendir within 24 hours after death.

To the Funeral Director: A completely filled in by the fu death.

Physician

Examiner

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at

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/Medical

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29d. Date signed (Month, Day, Year)

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Baltimore

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Contract of

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Robert H Keys, Jr. Physician Month October 11, 1:45 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 3015 Freeway Lansdowne Baltimore 6. Sex 1 M 2 □ F If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs, last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months Director 2<u>16-30-7663</u> Feb. 8, 1934 Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be analisted. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Baltimore MD Lansdowne 1 ☐ Yes 2 XNo Funeral Director 3015 Freeway 10f. Zip Code 10g. Citizen of What Country? 21227 United States 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 XYes 2 No 1951 **–** If Yes, Give Year or Dates: 1954 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 XYes 2 No Specify: Specify: White Completed by 3 Widowed 4 Divorced 1954 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Baltimore Gas & Elementary(Secondary (0-12) College (1-4or 5+) Troubleshooter Electric Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Robert H. Keys, Sr. Evelyn Wiggnigton ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3015 Freeway, Lansdowne, MD 21227 Lottie M. Keys - Wife 20b. Place of Disposition (Name of cemetery, crematory or other place)
Meadowridge
Memorial Park 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from state 10-15-2007 Elkridge, MD □ ponation 5 □ Other (Specify) Ambrose Funeral Home, Inc. 22. Name and Address of Facility 2719 Hammonds Fry Rd., Lansdowne, MD 21227 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Agset and Death Immediate Cause (Final **Physician** small cell disease or condition resulting in death) mo /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an this certificate 1∏ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 Inpatient Certification: To 2 ER/Outpatient 3□ DOA Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral I Medical 29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of wath (Item 23a) (Type, Print) Cotenaue BALT MD 21220 Carole

Registrar

31. Date filed (Month, Day, Year) 2007 OCT 1 6

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NOPON 32 Registrar's Signature

Division or Vital Records, P.O. Box 68760, Hospital or Attending Physician: reral Director: /

28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29d. Date signed (Month, Day, Year)

29c. License number

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MARYLAND 21204

State

Medical

FRANCIS 31. Date filed (Month, Day, Year) Registrar 6 001

29b. Signature and title of certifier

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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within 24 hours a

State of Maryland / Department of Health and Mental Hygien 7 33007 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 12:35 AM **Physician** 2007 IRENE WOELFER KENDALL /Medical 4c. County of Death Eacility Name (If not institution, give street and number Be) RIT HEAL HAT R 4b. City, Town, or Location of Death Examiner Vactor teal-th+Renab If Under 24 Hrs. Birthplace (State or Foreign Country) Year 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) **Funeral** Min. Months Days Hours 1 M 2 F Mar. 25, 1918 Illinois Director 366-07-3514 89 Usual Residence of Decedent 10d. Inside City Limits the Maryland 10b. County 10c. City, Town or Location 10a. State 28a-f ehow in than "natural", or iteme 23a or 28a-f ehov the Medical Examiner must be notified at 1 ☐ Yes 2√2 No Directo Maryland Harford Bel Air 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 212 B Timber Trail USA 21014 death 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. e filed within 72 hours after I Hygiene. other than "natural; or ite 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White 3 ☐Widowed 4 ☐ Divorced 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Public Education permit. Pages 1 and 2 should be filed w Department of Health and Mental Hygier important: if itsm 27 is marked other th any injury or other traumatic event, the ODGs. Secretary 12 18 Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Chisom Clinton David Woelfer Nellie E. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 212 B Timber Trail, Bel Air, Maryland 21014 Janet Gilman / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Hilltop Service Corp. 10-16-07 Towson, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Name and Address of Facility Home, P.A. McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 21. Signature of Funeral Service Licenses 23a. Part1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any learning is immediate cause. Enter Underlying Cause (Disease or injury that initialed events resulting in death) Last Due to (or as a consequence of) Examiner attending physicien and for use as the burial-transit Due to (or as a consequence of) P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 □Ectopic pregnancy Day Month Year ned by the atte in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown certificete has been signed by rector, page 2 should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 2, No 3 Probably 4 Unknown le 1 ☐ Yes Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No performed? 1 ☐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 45 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 9 1 Inpatient 2 ER/Outpatient 3 DOA 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? Certification: After or Attending 1P Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident Director: 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide To the Hospital within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical 29c. License number 29d. Date signed, (Month. Day, Year) 29b. Signature and title of certifier 256545 10/12/0. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SHIRI KHOS 4 206 HAYS ST, #102, BEL AIR, MD 21014 boules 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 1 6 2007 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Date of Death
 Month 1. Decedent's Name (First, Middle, Last) Day **Physician** John R. Kelz October 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Union Memorial Hospital Baltimore N/A If Under 1 Year If Under 24 Hrs. T 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1**X**2M 2□ F 72 Director 216-30-7270 6-30-1935 Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If then 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Francisco. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1. Yes 2 No Funeral Director N/A MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3831 Hickory Avenue 21211 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married I ☐ Yes XX No f Yes, Give 1 ☐ Yes 2XXXIo Specify 2 White 3 ☐ Widowed ★ Divorced Year or Dates Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Construction Brick Layer 10 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Alphonse J. Kelz Anna Frances Miller ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Justine F. Naumann Sister 1809 Parkwood Drive Forest Hill, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State XX Burlal 2 ☐ Cremation 3 ☐ Removal from State Dulaney Valley Memorial 10/16 5 Other (Specify) 4 □ Donation Cockeysville, Maryland Garden: Address of Facility
Burgee-Henss-Seitz Funeral Home, Funeral Sea 21. Signatu 3631 Falls Road Baltimore, Maryland ease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, are. List only one cause on each line. 23a. Part1. Enter the diseas shock, or heart valure. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physiclan Cardonyopath Induces Alcohol 1 year /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, liany, leading to inmediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 attending physician Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav 4☐Pregnant at time of death 5 Other (specify) 9□Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy perform 2 💟 1∐ Yes or Attending Physician; 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After Certification: 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No after death.

Director: / 2 Accident 3 ☐ Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the Hospital o within 24 hours aft To the Funeral Di completely filled in 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Watter, MD October 12,2007 arthony D0063657 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) East University PKWY., Baltimore, MD 21218 200 Watkins, mo 31. Date filed (Month, Day, Year) Anthony

Registrar

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

	_1	For State Registrar		iryiand	-	rtment of He tificate of D		F	eg. No	007	33009
Physicia	in	1. Decedent's Name (First, Middle, L Ratni Kaushal	ast)					2. Date of Dea Month Octobe1	Dav	2007	3. Time of Death 3:00 P M
/Medic Examin	_	4a. Facility Name (If not institution, g				4b. City, Town, or L Elkridge			4c. C	County of Death Howard	
Funeral Director		5. Social Security Number 6.		92	t birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day April 2	'. Year)	9. Birth	place (State or Foreigr ntry) ndia
-f show lled at		Usual Residence of Decedent 10a. State 10b. County MD Howard	đ		Town or Loc ridge	cation					10d. Inside City Limits
23a or 28a ist be notil	Funeral Director	10e. Street and Number 6371 Rowanberry	Drive			10f. Zip Code 21075			Ind		
or of ream and women rygence. The man and women rygence or or other traumatic event, the Medical Examiner must be notified at or other traumatic event, the Medical Examiner must be notified at	by Funer	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced	12. Was Decedent I Armed Forces? 1 ☐ Yes 2 ☑ N If Yes, Give Year or Dates:	Ever in U.S. No		Vas Decedent of His i Yes, specify Cuban ☐ Yes 2X No	panic Origin? (Sp , Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		4. Race - Ameri Black, White Specify: Asia	
an "natura e M-dical E	Completed	15. Decedent's (Specify only highest s	Education grade completed) College (1-4or 5	171	(Give life. E	ent's Usual Occupa kind of work done do OO NOT use retired)	tion uring most of work	sing 1		od of Business/Ir	
en 27 is marked other than ther traumatic event, the N	Be	17. Father's Name (<i>First, Middle, La</i> Bhisamber Das Sar			H	omemaker	18. Mother's Nam				-
Is marked of	OT.	19a. Informant's Name/Relationship (Type. Print) Remesh Kaushal (son) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, St. 6371 Rowanberry Drive, Elkridge, MD 2									
Important: If Item 27 any Injury or other tr		Remesh Kaushal (son) 20a. Method of Disposition 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) Metro Crematory 22 Name and Address of Facility									
Importan any injur once.		21. Signature of Funeral Service Lice	1		22		s of Facility France Fluner	al Home a	t MMP	, Inc.	
sician ledical aminer	l Examiner	23a. Part 1. Enter the disease, or or shock, or heart failure. List or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	a	a conseque	ence of):	noni	5				Onset and Death
the attending physician and thed for use as the buriat-transit	Physician/Medical	d									ivery Day Year
been signed by the should be detached	b	Part II. Other significant condition	s contributing to death b	ut not result	ting in the u	nderlying cause give	n in Part I.	23e. Did t			the cause of death?
certificate has beer irector, page 2 shou	Completed							24a. Was auto perfo 1∐ Yes		prior to c	topsy findings availa completion of cause o 2 No
this di	To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death	Hospital: 1 ☐ Inpati		R/Outpatier	other	4 LI Nursing H	th (Check only of the lome 5 Resi	dence (cify)
Within 24 hours after local. To the Funeral Director. After completely filled in by the funeral funer	Certification:	1 Matural 5 Pending investiga 2 Accident 3 Suicide 6 Could of determin	(Month, Da	y Year)	Injury ne, farm, str	Work	Yes 2 □ No		Street an	d Number or Ru	ural Route Number,
e Funeral	edical Ce	29a. Certifier 1 Certifying (Check only one) 2 Medical E	Physician: To the best xaminer: On the basis of and manner st	of examination	/ledge, deat on and/or ir	h occurred at the tin	ne, date and place pinion, death occi	e, and due to the urred at the time	cause(s) date and) and manner as d place, and due	s stated. e to the cause(s)
Toth	Me	29b. Signature and title of certifier	صن	en		29c. License	e number G 81_	6	29d. Dat	te signed (Mont	h, Day, Year)
0		30. Name and address of person w	ho completed cause of	teath (Item	23a) (Type,	Print) 75	-RIT	COIL	th	oy (alen Ku
Sta Regist	ate rar	31. Date filed (Month, Day, Year)		rar's Signati	ure	sell !		•		,	MD21

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Dav 6:24 PM Charles A. Lupton, Sr. TUB EVR 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death BALTIMORS N/A SAINT HENES HOSPITAZ 8. Date of Birth (Month, Day, Ye Jul. 31, If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 1 M 2 □ F 7. Age (In yrs. last birthday) 5. Social Security Number Year) Hours Months Days 85 1922 219-07-8983 Maryland Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 No Baltimore MD Catonsville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21228 United States 1-F Stayman Court Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify White Specify: 1945 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Accountant Railroad 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) John Lupton Alice Farniholt 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1-F Stayman Court, Catonsville, MD 21228 19a. Informant's Name/Relationship (Type. Print) Dorothy E. Lupton - Wife Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Method of Disposition Burial 2 Cremation 3 Removal from State Doudon Park Cemetery | 10-13-2007 | Baltimore, MD 4 ☐ Ponation 5 ☐ Other (Specify) 21. Signature pi Funeral Service 22. Name and Address of Facility Ambrose Funeral Home, Inc. WOD 2719 Hammonds Fry Rd., Lansdowne, MD 21227 it1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CEPEBROUMS CULAR MECLOSINT 20 0144 Due to (or as a consequence of) unknavi ATRIUL + CONCLUATION Esquentiary let sondifice, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? CHUPIO MYOP WILTY 1 Yes 2 No 3 Probably 4 Unknown 324325 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an orong v-wy autopsy performed? 2 No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 3□ DOA 1 Mnpatient 2 ER/Outpatient

Physician /Medical Examiner

Physician

/Medical

Examiner

Director

Funeral

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Completed

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Physician/Medical

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Certification:

Medical

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

attending physician After this 24 hours after death Funeral Director:

Hospital or Attending Physician: The law requires that the death certificate be executed

Box 68760,

P.0.

Records,

Division or Vital

Completed 25. Was case referred to medical examiner? Be 1 ☐ Yes 2 2No P

27. Manner of eath 1 Natural 5 Pending investigation 2 ☐ Accident 6 ☐ Could not be 3 Suicide

28a. Date of Injury (Month, Day Year)

28b. Time of

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

4 ☐ Homicide

1 Vertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

29b. Signature and title of certifier

29c. License number 500 60105 29d. Date signed (Month, Day, Year) 0 CTUBER 20 2007

10.41

within 2.

31. Date filed (Month, Day, Year) State

30. Name an address

32. Registrar's Signature

2007

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Registrar

State of Maryland / Department of Health and Mental Hygiene 3301 For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Day Year **Physician** 3, 2007 6:15 P IRIS MEYER LUFBURROW OCTOBER /Medical 4c. County of Death 4a. Facifity Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Harford Memorial Hospital Havre de Grace Harford If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** 1 M 2 X 220-18-4348 80 1927 Maryland Director 24, Usual Residence of Decedent the Maryland 10d. Inside City Limits 10b. County 10c. City. Town or Location 10a. State ith and Mental Hygiene. 27 ie marked other than "naturel", or iteme 23a or 28a-f show treumatic event, the Modical Examinar must be notified at 1 Yes 2 No Directo Marvland Harford Bel Air 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 33 Bonnie Avenue 21014 by Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No ff Yes, Give Year or Dates: 1 Never Married 2X Married 1 ☐ Yes 2 ☑ No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Efementary/Secondary (0-12) Coflege (1-4or 5+) 10 Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be (unk) Tyler Lula Charles ျှ (unk) Mever 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 33 Bonnie Avenue, Bel Air, MD 21014 John E. Lufburrow Sr./ Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Woodlawn Cemetery 10-17-07 Baltimore, Maryland 22. Name and Address of Facility
McComas Funeral Home, P.A. 21. Signature/of Funeral Service License 1317 Cokesbury Road, Abingdon, Maryland 21009 Approximate Interval Between Onset and Death 23a. Part1. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. fmmediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a conseque Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events (or as a consequence of) Examiner The law requires that the death certificate be executed for use as the burial-transit 10 resulting in death) Last Records, P.O. Box 68760. Physician/Medicai IF FEMALE: If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Year Day 5 Other (specify) 4 Pregnant at time of death page 2 should be detached 9 Unknown à 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 🗆 Yes 2 1 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 2 No 1 Yes 2 100 or Attending Physicien: director. Be 25. Was case referred to medical 26. Place of Death | Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Impatient Certification: To 1 ☐ Yes 2 No 2 ER/Outpatient 3□ DOA funeral 27. Mann of Death 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After Injury Division 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident the within 24 hours after deatl To the Funerel Director: 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 - Homicide Hospital 🔁 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical To the Fund completely fi 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License numbe 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a), (Type, Print) C 82. Registrar's Signature 31. Date filed (Month, Day, Year) State 6 2007 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2007 33012

		- For State egistrar	Certifica	ite of D	Death			Reg. No	200		, 0 1 1
Physician		. Decedent's Name (First, Middle,Last)					2. Date of D Month	Day	Year	3. Time of Dea	
ledical Examin		Heidi Marie Lanam					October	1, 200)7	1025 hrs	
	4	la. Facility Name (if not institution, give street and numbe 9261 Crazy Quilt Court	r)		City, Town, or Columbia	Location of I	Death		c. County of Dea Howard	itri	
Emand	F		ge (In yrs. last birth		If Under 1 Yes	ar If Under 2	24Hrs. 8. Date of	Birth (MN	//DD/YYYY) g. E	Birthplace (State of	unk
Funeral Director			45	Yrs.	Months Day		Min. Aug !		For	eign Country) CA	
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Maryland 28a-f show 1 at once.	Ulrector	10e. Street and Number			10f. Zip Code	, ₋		10g. Ci	itizen of What Co	ountry?	
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5-0036 led within 72 hours after death with the Maryland Hygiene. other than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at once.		1 Yes 3 Widowed 4 Divorced If Yes, Give Year	2 X No	1 Y	es 2 X N	n specify:			Specify: w	nita	
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21215-0036 July be filed within 7. Mental Hygiene, marked other than c event, the Medical	5 L	unk 5+		Comput	ter Prog				mputer Te	chnology	
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121 d be fi ental arked vent,	8	Trevor Henry Lanam	140	. Marilian /	Address (Char	Edna	<u>Kapitski</u>	Numbas	City or Town St	ato, Zin Code)	
Imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f shu or other traumatic event, the Medical Examiner must be notified at one.	의	19a. Informant's Name/Relationship (Type, Print) Douglas Lanam/ brother	199	239 Mo	untain V	iew Ave.	er or Rural Route Mountain Baltimor	View.	CA 94041	L	
ore, MD st and 2 sho of Health and If item 27 is ner traumati	-	20a. Method of Disposition	20b. Place of	of Dispositi	on (Name of c		Date	200	c. Location - City	or Town, State	
Baltimore, M permit. Pages I and 2 Department of Health Important: If item 2 injury or other traum	-	1 Burial 2 X Cremation 3 Removal from	7 A	ory or othe			10/18/2007	, ,)_1+~;11_	M	
Baltime permit. Page Department Important: injury or ot	-	4 Donation 5 X Other Specify: in 6ta 21. Signature of Funer Service Licensee	te Unesap		rematory me and Addre		Going Home		eltsville etise Svo		78/1
Balt permit. Depart Impor	-	Ronald S. Wate	irector		ito Ana Ltimore		21201 (Jarks	wille M	21029	204
Physician	7	23a. Part I. Enter the disease, of complications that cause failure. List only one cause on each line.	ed the death. Do no	ot enter the	mode of dying	g, such as car	rdiac or respiratory	arrest, s	shock, or heart	Approximat Between O	
/Medical xaminer	ł	Immediate Cause (Final disease a. No Anaho	mic or Tox	icolog	ic Care	of Deat	h			Dea	ith
		or condition resulting in death) Due to (or as a con	nsequence of):								
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50, tte be nysicii	탕	Δ	5 9 11 15 come of pregnancy	16a-b.	17,18,19	ab., 20a-	-c 22 perFl	C872	2 d. Dale of deli		
68760, certificate be nding physic ise as the bur		23b. Was decedent pregnant in the past 12 months?		Feta	death 3	Ectopic	pregnancy		Month	Day	Year
Box 687 e death certiff the attending ed for use as t	sici	1 Yes 2 No 9 V Unknown 9 Unknown		5 Oth	er (Specify)			- 1			
that the de ned by the detached f	Physician	Part II. Other significant conditions contributing to de		g in the un	derlying cause	given in Par	t I. 23e. [oid tobac	co use contribute	e to the cause of o	death?
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ion tendin eath. or: A	틽	1 Natural 5 Pending 10-1-07		:00am	1_	Yes 2X			_		
Division of Vital Records, P.O. Box 68 within 24 hours after death. To the Hospital or Attending Physician: The law requires that the death certif at hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Certification:	3 Suicide 6 X Could not be 28e. Place o	f Injury - At home, f	arm, street	, factory, office	e building, etc				r Rural Route Nur	
Dj spital cours a reral J	ह	Tierniciae	residence				Columb	ia, II	Cou	nty, Mil.	00.
To the Hos within 24 h To the Fun completely		29a. Certifier (Check only one) Certifying Physician: To the best of Medical Examiner: On the basis of each of the basis of the basis of each of the basis of the	f my knowledge, de	ath occurr	ed at the time, on, in my opini	date and place on, death occ	ce, and due to the curred at the time.	cause(s) date and	and manner as place, and due	stated. to the cause(s)	
To the within To the comple	Medical	one) 2 Medical Examiner: On the basis of eand manner state 29b. Signature and title of certifier				nse number				(Month, Day, Year	r)
		, \	no		1	C.M.E.		lo	october 2, 20	07	
		30. Name and address of person who completed cause									
115/	1	Ling Li, MD Assistant Medical Examil		n Street	t, Baltimore	e, MD 212	01				
St	ate	31. Date filed (Month, Day, Year) 32, Regis	strar's Signature	- 4							
Regist		OCT 1 6 2007 FROM	of Sand and a	LONA							

33013 State of Maryland / Department of Health and Mental Hygien [9] Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 10-12-2007 **Physician** 845 A Julia A. McCauley /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Harford Fallston 108 Fallston Meadow Ct Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 2**X** F 49 Maryland 08-04-1958 Director 217-56-9350 Usual Residence of Decedent 10d. Inside City Limits the Maryland 10c. City, Town or Location 10a. State rthen "natural", or items 23a or 28a-f ehov the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Fallston Maryland Harford 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21047 U.S.A. 108 Fallston Meadow Ct Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Never Married 2 🛣 Married 1 Yes 2 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: White Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) alth and Mental Hygiene. 27 ie marked other then ir traumatic event, the Me College (1-4or 5+) Elementary/Secondary (0-12) Medicine Nurse 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Margaret McIntyre Charles Schaefer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Department of Health a important: If item 27 is eny injury or other traugules. Bruce A. McCauley (Husband) 108 Fallston Meadow Ct Fallston, MD 21047 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 10 15 07 Baltimore, Maryland 4 Donation 5 Other (Specify) Bayview Crematory 22. Name and Address of Facility Schimunek Funeral Home of Bel Air 21. Signature of Funeral Service Licensee Inc. 610 W. MacPhail Rd Bel Air, MD 21014 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed attending physicien and for use as the burial-transit Physician/Medical Exami Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed 1 Yes 2 After this certifice funeral director, p 26. Place of Death (Check only one) Be 25. Was case referred to medical Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No ဥ 28c. Injury at Work? 27. Manner of Ceath 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Medical Certification; 1 Natural 5 Pending 1 Tes 2 No death. 2 Accident investigation within 24 hours after death To the Funeral Director: , completely filled in by the f 6 ☐ Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 000BGR 12, 2007 D47934 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BARIMORE NO 2/20 57, 32. Registrar's Signature 31. Date filed (Month, Day, Year) State OCT 1 6 2007 Sprite

DHMH 17 Rev 1/2001

Registrar

Certificate of Death

Date of Death
 Month

10-12-2007

Day

3. Time of Death

750 A

1 - For State Registrar

Physician

1. Decedent's Name (First, Middle, Last)

Pauline V. Maximuk

)	Examin	er	4a. Facility Name (If	not institution, giv	e street and nu	ımber)			4b. City, Towr	n, or Location	on of Death		4	c. County	of Deat	h
Stella Maris								Tows	on]	Balti	more	е	
	Funeral		5. Social Security No			7. Age (/	In yrs. last bi		If Under 1 Ye Months Da			8. Date of Bi (Month, D	rth av. Yea	r)	9. Birtl	hplace (State or Foreign untry)
ш	Director		214-03-5	418	□M 2 ∑ F		87	Yrs.		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		12-30-				yland
	ը .		Usual Residence of			" 44	On Oile Too		-4i							404 1
	rylar how	_	10a. State	10b. County		11	0c. City, Tow	n or Loca	ation							10d. Inside City Limits 1 ☐ Yes 2X No
	e Ma a-f s tifiec	양	Maryland	Baltim	ore		Kin	gsvi	11e							
	th th	ire	10e. Street and Nun	nber					10f. Zip Cod	e			10g. C	Citizen of W	/hat Co	untry?
	th wi	<u>a</u>	704 Kare	n Drive					210	87			U.	S.A.		
	dea	Funeral Director	11. Marital Status		12. Was Dec	edent Eve	er in U.S.	13. W	as Decedent of	of Hispanic	Origin? (Spican, Puert	pecify Yes or N o Rican, etc.)	0-		e - Ame k, White	rican Indian, e. etc.
9	after or Ite	F	1 Never Marri	ed 2 Married		2 No			□Yes 2DX1			,		Specify:		
93	72 hours after death with the Maryland natural", or Items 23a or 28a-f show lical Examiner must be notified at	g P	3 XWidowed	4 Divorced	Year or D	Dates:								Ореслу.	Wh:	ite
21215-0036	72 h natu dical	Completed by	(Spec	15. Decedent's Edify only highest gra	ducation ade completed))	16a	. Decede (Give ki	nt's Usual Oc ind of work do O NOT use rei	cupation ne during r	nost of wor	king	16b.	Kind of Bu	siness/	Industry
21	ithin Ian " Me	d d	Elementary/Secon	ndary (0-12)	College ((1-4or 5+)		_		tired)			D			Chana
2	ygier ygier t, the	3	5				5	ares	person	1 40 14		(F) . As: 14				Store
nd	be fil tal H d ott	Be	17. Father's Name (ne (First, Middle	e, Maide	en Surnam	9)	
<u>y</u> a	Men arke	၉		ista Var							ary G					
Maryland	is 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene. The filed you state that any family state of the wind that any state of the world is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		19a. Informant's Na	, ,	• •	_		-				ral Route Num			State, 2	Zip Code)
2	and ealth n 27 ner tr		Marie Ro		ough (D						Kings		_			
ore	iges 1 if itel or oth		20a. Method of Disp	osition ⊒Cremation 3 ☐	Removal from		cemete	ry, crema	tion (Name of atory or other	place)		Date	20c.	Location -	City or	Town, State
Baltimore,	permit. Pages 1 an Department of Heal Important: If Item 2 any injury or other once.			5 ☐ Other (Specif			Garde		Faith		10-1	5-2007	Bal	timor	e, 1	Maryland
alt	permit. Pa Departmer Important: any injury once.		21. Signature of Fu	neral Service Lice	nsee			22.	Name and Ad	Idress of Fa	acility Sc	himunek	Fun	neral	Hom	e of Bel Air
<u> </u>	9 Q E 8 9		1-6	XU	1							il Rd E		Air,	MD :	21014
	1 4		23a. Part1. Enter the shock, or hea	ne disease, or com rt failure. List only	plications that one cause on	caused the	e death. Do	not enter	the mode of	dying, such	as cardiac	or respiratory	arrest,			Approximate Interval Between
	Physician		Immediate Cause (disease or condition						AILURE							Onset and Death
	/Medical		resulting in death)		a		onsequence		. I L L O I CL							
100	Examiner				h											
7		ner	Sequentially list cor if any, leading to im cause. Enter Unide Cause (Disease or	mediate	Due to	(or as a c	consequence	of):								
	eath certificate be executed attending physician and for use as the burial-transit	Physician/Medical Examiner	triat initiated events		C											
	e exe an ar irial-t	Ĕ	resulting in death) L	ast	Due to	(or as a c	consequence	of):								
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99	ng ph as t	Med	IF FEMALE:													
Box	th ce rendi	au/	23b. Was decedent		23c. If yes, ou 1□Live	utcome pf birth 2	pregnancy □ Fetal deat	n 3 🗆 8	Ectopic pregna	ancv				23d. Date		
	000	Sici	in the past 12	J No	4□Preg 9□Unki		ne of death	5 🗆	Other (specify	<i>'</i>)				Mor	IUI	Day Year
P.0	tac ph	h'S	9 ☐ Unknown			-	-					44				
. 5	gned be del	by	Part II. Other signif	icant conditions	contributing to	death but r	not resulting	n the und	derlying cause	given in P	art I.					the cause of death?
Records	w requires been signi should be											1] Yes	2 No	3∐ Pr	robably 4 Nunknown
ည္ပ	e fawr has be je 2 sh	ple										24a. Wa	s an opsy	24b. V	Nere au	utopsy findings available completion of cause of
		Completed										per 1□ Yes	formed?	? d	leath?	·
ta	ik-lan: Th certificate ector, pag	Be	25. Was case refer	red to medical						26. P	lace of Dea	th (Check only				
>	S S S	10	examiner? 1 ☐ Yes 2 X	No	Hospital: 1	Inpatient	2 🗆 ER/O	utpatient	3□ DOA	Other: 4 [Nursing H	ome 5 Re	sidence	6 X Othe	er (Spe	city) HOSPICE
0			27. Manner of Deat		28a. Date	e of Injury nth, Day Y	28b.	Time of Injury	28c. i	njury at Work?		28d. Describe				
Ö	Attending I r death. ector: After by the funer	atio	1 XNatural 2 ☐ Accident	5 ☐ Pending investigation		inin, Day	out,	,,		1 ☐ Yes 2	2□No					
Division or Vital	Atte	ifi	3 ☐ Suicide 4 ☐ Homicide	6 Could not b determined	20e. Flat	e of injury	- At home, f	arm, stree	et, factory, off	ice		28f. Location City or T			er or Ri	ural Route Number,
Ö	al Dir	Certification:				ag, o.o. ((0,000)					only or v	o, o	,		
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	ial (29a. Certifier (Check only	1 Certifying Pl	nysician: To th	e best of a	my knowledg	e, death	occurred at th	ne time, dat	e and place	e, and due to th	e cause	e(s) and ma	nner as	s stated. e to the cause(s)
	he H in 24 he Fi	edical	one)	∠ wedical Exa		nner state		na/or IIIV	osugation, in f	ny opinion,	uedin occi	med at the time	e, uale a	and prace, a	and dut	o to the cause(s)
	To t To tl	ž	29b. Signature and	Itle of certifier)				29c. Lic	ense numb			29d. [Date signed	d (Mont	th, Day, Year)
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			30. Name and addr	ess of person who	completed cau	use of deat	th (Item 23a)	(Type, P	rint)					. ,		

State Registrar DR. TARIQ MAHMOOD

31. Date filed (Mo CCT), 16ar 6 2007

2300 DULANEY VALLEY RD. TIMONIUM, MD 21093

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

M. SHEKITKA

KRISM. 5 H 31. Date filed (Month, Day, Year) D0037359 OCTOBER 11,2009

GOOCATONAVE BALTIMORE, MD21229

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** ZELDA **GEMAN MEGGINSON** 9 10 2007 10:50a /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** 143 Willard Street Baltimore, NA Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Days Months Hours 1 □ M 2**X** F 216-86-7239 6-3-1964 Md. Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County marked other than "natural", or items 23a or 28a-f show imatic event, the Medical Examiner must be notified at 1 XYes 2 No Baltimore NA Director Md. 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 21223 143 Willard Street Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married 3 Widowed 4 Divorced Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: þ Black Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) State of Md. Correction 12th grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) iges 1 and 2 should be fill it of Health and Mental H Be ပ CHARLES RANDOLPH LAMBERT CHRISTINE BREEDLOVE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 143 Willard Street, Baltimore, Md. Husband Michael Megginson Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Pages 1 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ortant: If i permit. Page Department o Important: If any Injury or King Mem. Pk. 10-16-07 Randallstown, Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March F.H. East adre 21202 1101 E. North Ave., Baltimore, Md. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician YVIO /Medical Due to (or as a consequence of): Examiner obesi Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last bus to for as a consequence of Examiner The law requires that the death certificate be executed signed by the attending physician and defected by the attended for use as the burial-trans Due to (or as a consequence of) Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Dav Month in the past 12 months?
1 ☐ Yes 2 ☑ No 4□Pregnant at time of death 5 Other (specify) P.0. 9□Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown should peen: 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an cate has by page 2 s performed? (es 2 No 1□ Yes 26. Place of Death Check onl one Be 25. Was case referred to medical examiner? Hospital: 1 ☐ Inpatient Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3□ DOA 2 this 28c. Injury at Work? 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Medical Certification: (Month, Day Year) Injury 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide [Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After the completely filled in by the funeral

State Registrar 30. Name and address of person who co mpleted cause of death (Item 23a) (Type, Print) ion Dow Kioune 31. Date filed (Month, Day, Year)

1

2007

29b. Signature and title of certifier

32 Registrar's Signature

Ron 206

031865

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Ssau October 13 200 V /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner UPPER CHESAPEAKE MEDICAL CENTER BELAIR
If Under 1 Year | If Under 24 Hrs. HARFORD CO 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number **Funeral** Days Hours Months 1**⊠**M 2□F Yrs Director 258-34-5095 81 APR. 29 1926 GEORGIA Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County "natural", or items 23a or 28a-f show edical Examiner must be notified at 1 ☐ Yes 2 X No Director MARYLAND HARFORD CO **EDGEWOOD** 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code permit. Pages 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturat", or Items 23a or : 1727 HARBINGER TRAIL 21040 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 🕅 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: BLACK Completed by 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry the Medical Elementary/Secondary (0-12) College (1-4or 5+) BRICK MASON CONSTRUCTION 8th grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ESAU MITHCELL SR. 2 MARIAH MITCHELL 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1727 Harbinger Trail, Edgewood, Md., 21040
of Disposition (Name of Date 20c. Location - City or Town, State Patricia D. Boone/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition ö XXBurial 2 ☐ Cremation 3 ☐ Removal from State injury BRYAN NECK BAPT CHR | 10-20-07 RICHMOND, GEORGIA 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
WILLIAM C BROWN COMM FUNERAL HOME-HARFORD, P.A.
321 S PHILADELPHIA BLVD., ABERDEEN, MD 21001 21. Signa ure of Funeral Service Licensee Derhara 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician 6 days disease or condition resulting in death) ZNterococcus /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner requires that the death certificate be executed and burial-trar Due to (or as a consequence of): Box 68760, physician Physician/Medical the as attending properties for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 Unknown signed t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown cate has been signated bage 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy ST Segmen 1 Yes 2 No Notacet Division or Vital NON funeral director, 25. Was case referred to me al 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1/1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes this 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? After t Certification: To the Hospital or Attending I within 24 hours after death.

To the Funeral Unrector: After 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day,

PSON

2011 32. Registrar's Signature

homo you 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Year)

DO053568

-07954		Please Type or Print in Black Indelible Ink. Ensure All Copi	es Are Legio	ile.
Ivatore Anthony		0 (15) (5 17) 4/-		2007 330
		a giptror	Reg. N 2. Date of Death	3. Time of Death
		Decedent's Name (First, Middle,Last)	Month Da October 11, 2	y Year 2312 hrs
dical Examin		Salvatore Anthony Munafo, Jr. 14b. City, Town, or Location of Dea		4c. County of Death
	1	4a. Facility Name (if not institution, give street and number) 405 Chapelwood Lane 4b. City, Town, or Location of Dear Lutherville Timonium		Baltimore County
	Щ.	400 Chaperwood Lanc	rs. 8. Date of Birth (M	M/DD/YYYY) 9. Birthplace (State or
Funeral	- 1	Months Days Hours M		. 1953 Foreign Country) Maryland
Director		217-62-5820 1XM 2F 54 Yrs.	1101 - 17	, 1900 Mid y 1 and
>		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits
w any				1 Yes 2 X No
land -f sho	호	MD Baltimore Lutherville 10e. Street and Number 10f. Zip Code	10g.	Citizen of What Country?
Mary r 28a	Director	405 Chapelwood Lane 21093	lυ	SA
rdeath with the Maryland or items 23a or 28a-f show must be notified at once.		400 Citape (Wood Earle	Specify Yes or No-	14. Race - American Indian, Black,
ems the	Funeral	11. Martial 2 Martiad 2 Armed Forces? If Yes, specify Cuban, Mexican, Puer	rto Rican, etc.)	White, etc.
or it	킚	1 Yes 2 X No		_{Specify:} white
s afte	최	or Dates:		Sb. Kind of Business/Industry
hour natu	te l	15. Decedent's Education (Specify only highest grade completes) during most of working life. DO NDT use r Elementary/Secondary (0-12) College (1-4 or 5+)		1/4
36 in 72 than dical	읦	12 1 N/A	Į N	I/A
with giene	Completed	17. Father's Name (First, Middle, Last)	me (First, Middle, Mai	
al Hy et of	Bec	Salvatore Anthony Munafo Edna M	. Herrmanr	
Ment mark	10	190 Informant's Name/Relationship (Type Print) 19b. Mailing Address (Street and Number of	or Rural Route Number	er, City or Town, State, Zip Code)
Imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. tant: If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at once.		Joann Koch / sister 405 Chapelwood Lane;		16, MD 21093
e, Nand Health		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)	Date 2	20c. Location - City or Town, State
Baltimore, permit. Pages I ar Department of Hee Important: If ite	- 4	1 Burial 2 Cremation 3 Removal from State Ontone Property Valley Mem Cardens 1	0/15/07	Timonium, MD
Baltimo permit. Page Department o Important: injury or oth	- Vi	24. Name and Address of Lacinty		1050 York Koad
Ba perm Depi	1.15	Ruck Towson Funer 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardia		Towson, MD 21204
;aminer	Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Methadone and alcohol intoxication complication. Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):		
e executed cian and rial - trans	cal	XUNPENDED		
Division of Vital Records, P.O. Box 68760, Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. Fineral Director: After this certificate has been signed by the attending physician and tely filled in by the funeral director, page 2 should be detached for use as the burial - transit	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnant at time of death 5 Other (Specify) 9 Unknown		23d. Date of delivery Month Day Year
the de check	Phy	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tob	vacco use contribute to the cause of death?
P.O.	ğ	Hepatic cirrhosis and steatosis	1 Yes	- Company of the second
Division of Vital Records, real or Attending Physician: The law require and redeeds and before and Director. After this certificate has been signed in by the funeral director, page 2 should b	Completed by		24a. Was a autops perform	y prior to completion of cause of ned? death?
F. The tifficar or, pag	ပြ	25. Was case referred to medical 26.Place of Death (Ch		
/ita sician is cer lirecto	o Be			Residence 6 V Dther: Scene
of Vi ing Physi After this	12	27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work?		ow injury occurred
OD (lioi	1 Natural 5 Pending Fnd 10/11/2007 Fnd 11:05 pm 1 Yes 2 X No		
Sic Atte er dea rectou by th	Certification:	2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc.	or Town St	treet and Number or Rural Route Number, Ci
Div tal or rs afte al Diu	it.	3 Suicide 6x Could not be determined (Specify) found at home	405 CHape	lwood Lane Lutherville, M
Division of Vital Rec To the Hospital or Attending Physician: The I within 24 hours after death. To the Funcral Director: After this certificate I completely filled in by the funeral director, page	၂ ပို	29a Certifier	e, and due to the cause	e(s) and manner as stated.
To the H within 24 To the F complete	Medical	Certifying Physician: To the best of my knowledge, dearn occurred at the time, date and place (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occur	rred at the time, date a	and place, and doc to the oddes(4)
To with	Mec	and manner stated. 29b. Signature and title of pertifier 29c. License number		29d. Date signed (Month, Day, Year)
		O.C.M.E.		October 12, 2007
, ,		30. Name and address of person who completed cause of death (Item 23a)		
100		Jack Titus MD. Deputy Chief Medical Examiner 111 Penn Street, Baltimore, M	D 21201	
1	127	31 Date filed (Month Partyper) A 0007 32, Registrar's Signature		
Regi	State	THE TABLE TO STATE OF THE PARTY		

OCTOBER 12, 2007 1:10 p.m.

EVELYN MOFFITT

			For State Registrar	Plea				d / Depa		. Ensure A Health and I <i>Death</i>	Mental Hy		gible.	33019
1			negistrar Decedent's Nan	ne (First, Midd	le, Last)						2. Date of De	ath	V	3. Time of Death
	Physici /Medi		Evelyn	Sinder	son Mof	fitt					Oct	12	Year 2007	1:10 P M
	Examir		4a. Facility Name (4b. City, Town,	or Location of Death	1	4c. Co	unty of Death	
	λ-ν		Stella			7 - 4			Timoni		8. Date of Bin		1timore	
	Funeral		5. Social Security I		6. Sex 1 □ M 21√2	F		ast birthday) Yrs.	Months Days	Hours Min.	(Month, Da	y, Year)	Coun	lace (State or Foreign try)
	Director		Usual Residence			8	86				May 19	192	I LA	
	ryland how		10a. State	10b. County	,		10c. City	, Town or Lo	ocation				1	0d. Inside City Limits
	e Ma 3a-f s	cto	MD	Balt	imore		Ti	imoniu						1 ☐ Yes 2X No
	with the Marylan a or 28a-f show t be notified at	Dire	10e. Street and Nu						10f. Zip Code			10g. Citizen	of What Coun	itry?
	be filed within 72 hours after death with the Maryland ttal Hygiene. d other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at	Funeral Director		ıLaney	Valley H		Ever in U.	S 13		21093 Hispanic Origin? (S	necify Yes or No		USA Race - Americ	an Indian,
	ter de Item iner r	Ę.	 Marital Status Never Mar 	ried 2∏ Ma	Arme	d Forces?	?			Hispanic Origin? (S pan, Mexican, Puerl	io Rican, etc.)		Black, White,	
21215-0036	urs al al', or Exam		3 √□ Widowed		I IT Yes	s, Give or Dates:		ļ	1⊡Yes 2⊠XNo	Specify:		Sp	e <i>cify:</i> wh	nite
20	72 ho natur lical l	Completed by	(Spe	15. Decede	nt's Education	ted)			dent's Usual Occu	pation during most of wor	rkina	16b. Kind	of Business/Ind	dustry
2	within iene. than "	du	Elementary/Sec		Colle	ge (1-4or	5+)	life.	DO NOT use retire	ed)				
12	filed w Hygie Ither tl		10 17. Father's Name	(First Middle	l act)	/a		Sec	retary	18. Mother's Nar	ne (First Middle		ailroad	
anc	ould be filed Mental Hygi arked other atic event, t	Be	Orren S	,	•									
Maryland	should be f and Mental I s marked of umatic eve	2	19a. Informant's)		19b. Maili	ng Address (Stree	t and Number or Ru	n_Belle_ ural Route Numb		own, State, Zip	Code)
N	alth al 27 Is or trau		Robert M	offitt	/Son			711 1	V. Univer	sity Pkw	v Balt	imore	MD 21	210
Je,	of He		20a. Method of Dis	sposition		04-4-	20b. P	lace of Disperentery, cre	osition (Name of matory or other pla	ice)	Date	20c. Locat	on - City or To	own, State
<u>E</u>	Page ment art: M		Donation		3 ∏Removal f Specify)	rom State	For	est Pa	ark Lawnd	lale 10	0/18/07	Houst	ton, TX	
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any njury o other traumatic ev onc.k.		21 Signature of	ynoral Say			_	L_{ϵ}^{2}	2. Name and Addr	ess of Facility Leral Home	e of Dul	anev V	Jallev.	Inc
	9 D = 8 9		Lowel		emmon			10	W. Pado	eral Home	Timoniu	m, MD	21093	Approximate
			shock, or he		t only one cause	on each l	ine.	n. Do not en	ter the mode of dy	ing, such as cardia	c or respiratory a	rrest,		Interval Between Onset and Death
	Physician /Medical		disease or conditi resulting in death	on	a.	MENTI	A a consequ	uanna of):						
8	Examiner					e to (or as	a consequ	uence on.						
		ner	Sequentially list c if any, leading to cause. Enter Und that initiated even	onditions, mmediate	Du Du	e to (or as	a consequ	uence of):						
	be executed ician and burial-transit	Examiner	that initiated even resulting in death)	ts	С.								-	
60,	be exe ician a burial-		resulting in death)	Lasi	Du	e to (or as	a consequ	uence of):						
687		Physician/Medical			d								- 4	
Box 6	certifi nding use as	/Me	IF FEMALE: 23b. Was decede	nt prognant			e pf pregna					23d	. Date of delive	erv
	death atter	icia	in the past 1	2 months?	4 □ F	regnant a	2 ∏ Feta at time of d		⊒Ectopic pregnand ⊒ Other <i>(specify)</i> _	cy .			Month	Day Year
P.O.	that the de led by the a detached t	hys	9 □ Unknow	n	9 0	Jnknown					-			_
	a de	by P	Part II. Other sign	ificant condi	ions contributing	to death I	but not resi	ulting in the u	inderlying cause g	iven in Part I.				he cause of death?
ord	w requir been si should I	ted									10	Yes 2□N	No 3∐ Prot	oably 4 Vunknown
ec		Completed									24a. Was		24b. Were auto prior to co death?	psy findings available mpletion of cause of
aF											1□ Yes	2X No	1 ☐ Yes	2 No
Xi	Physiclan: The law this certificate has tral director, page 2 s	Be	25. Was case refe examiner? 1 ☐ Yes 2		Hospital:	1 🗆 Inneti	iont 2 🗆	ER/Outpatie	nt 3□ DOA O	hori	ath (Check only o		704h (Cii	MOSPICE
0	y Phys er this eral dir	7: To	27. Manner of De	_	28a. I	Date of Inj	ury	28b. Time	III OLI DON	4 🗆 Nursing r	28d. Describe			M HOSPICE
ion	Attending r death. ector: After by the fune	ation	1 X Natural 2 ☐ Accident	5 ☐ Pend inves	ing tigation	(Month, D	ay Year)	Injury		Yes 2 □No				
Division or Vital Records,	r Atte er dea recto	Certification:	3☐ Suicide 4☐ Homicide	6 ☐ Could deter	I not be mined 28e. I	Place of in building, e	jury - At ho	ome, farm, st	reet, factory, office		28f. Location (City or To	Street and N wn, State)	lumber or Rura	al Route Number,
	ital or A Irs after ral Dire													
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical	29a. Certifier (Check only one)		Examiner: On	the basis	of examina			time, date and plac opinion, death occ				
	To the Howithin 24 To the Fusion plete	Med	29b. Signature an	id title of certif	-	manner s	iaieu.			ise number		29d. Date s	igned (Month,	Day, Year)
	FSFO				142	_			D	43725	_	/	0/12/0	7
	7		30. Name and ad	dress of perso	n who completed	cause of	death (Iten	n 23a) (Type		- 1- 1		,		
	l		DR. TAI		MOOD 23	300 D	ULANE	Y VAL	LEY RD.	TIMONIUM	, MD 210	93		
		ate	31. Date filed (Mo	onth, Day, Yea	no7 Rec	32. Regist	trar's Igna	ature						
	Regist	Tal	UC	ITAL	450			P						

		•	For Amend 1	State o 23a pe	f Marylar r dr., §	nd / Depa 872 C e	artment of l	lealth a Death	and Me	ental Hy	giene Reg. No. 2 (007	33020
A)	Dhusisi		1. Decedent's Name (First, Min	ddle, Last)						2. Date of Dea		Year	3. Time of Death
	Physici/ Medic		Leroy	Richard		M	iller	Sr.		Octobe			11:00AM
	Examir	er	4a. Facility Name (If not institu				4b. City, Town, c		of Death			y of Death	
	Funeval		1222 Broenii 5. Social Security Number	ng Highwa 6. Sex	Y 7. Age (In yrs.	last birthday)	Balti If Under 1 Year		24 Hrs.	8. Date of Birt		A 9. Birthi	place (State or Foreign
	Funeral Director		235-12-1673	1.XM 2□F	8		Months Days	Hours	Min.	8. Date of Birl (Month, Da July 22	, Year) 1,1920	Wes	Virginia
	pu ,		Usual Residence of Decedent				- A'						
	shov shov	5	10a. State 10b. Coul	I/A	100.01	ty, Town or Lo	timore						10d. Inside City Limits 1 X Yes 2 □ No
	the N 28a-f notifie	Funeral Director	10e. Street and Number				10f. Zip Code				10g. Citizen of	What Cou	
	3a or	٥	1222 Broening	Highway				224			USA		,
	deatl	ner	11. Maritai Status		edent Ever in U	J.S. 13.	Was Decedent of hif Yes, specify Cub	dispanic Original	gin? (Spec	cify Yes or No	14. Ra	ce - Americack, White,	
36	or ite	y Fu	1 Never Married 2 XM	farried 1 ☐ Yes If Yes, Giv	2 X No /e		1 ☐ Yes 2 ☐ No	Specify:	i, i dono i	110011, 010.)	Speci		ite
5-0036	72 hours after death with the Maryland natural", or items 23a or 28a-f show dical Ex miner must be notified at	q pe	3 Widowed 4 Divord	ed Year or Dident's Education	ates:		dent's Usual Occup	nation			16b. Kind of E	AATT	
15	in 72 n "na Medic	plet	(Specify only hig Elementary/Secondary (0-12	hest grade completed)	Acr Eu)	(Give	kind of work done DO NOT use retire	during most	t of workin	g	Crown Co		· _
2121	d with giene er tha , the J	Completed by	9 years	z) College (1	-401 5+)	Mach	inist						
nd	be file tal Hy d oth	Be	17. Father's Name (First, Midd								Maiden Surna	me)	
<u>ya</u>	12 should be filed within "h and Mental Hygiene. 7 is marked other than "raumatic event, the Mec	은	Charles Edward			405 84-00	Address (Otres	L		e Myers		0.4.7	
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Exeminer must be notified at once.		19a. Informant's Name/Relation Leroy Richard		Son		ng Address <i>(Street</i> B. Crock e				-		,
	s 1 an f Heal item 2 other		20a. Method of Disposition		20b. I		osition (Name of matory or other pla			er 13,	20c. Location		
E O	Page Tent o Int: If		1 XBurial 2 ☐ Crematic 4 ☐ Donation 5 ☐ Other		State		Cemetery	1	200		Dundal	k,Mar	yland
Baltimore,	permit. Departri Importa any inju		21 Ign ture of Funeral Servi	ice License)	1/1 2	2. Name and Addre	ss of Facilit	1 Hor	ne Of I	undalk	P.A.	
8	99 = 99		millong	- C. C.	mul	7	110 Solle	ers Po	oint I	Road, I	Dundalk,	Md.	
			23a. Part1. Enter the disease shock, or heart failure. I	, or complications that c List only one cause on e	aused the deat ach line.	th. Do pot ent	ter the mode of dyi	ng, such as	cardiac or	respiratory a	rrest,		Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)				t Failur						
	Examiner			Due to (or as a consec	luence of):	Heart Bl	ock	OT	CAL	140	E	
	10 Oct	Jer	Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to	or as a consec	quence of).	Anemia.	CH	17-1-	1711	F 4+6	-	
	cate be executed oblysician and the burial-transit	Examiner	triat initiated events	0. TVE	ART	BI	ock	-					
60,	oe execian a	Ě	resulting in death) Last	Due to (or as a consec	quence of):	H/O GI B	leed					
38760,	certificate be executed iding physician and ise as the burial-transit	dical		ā.	VETVL	(-/-							
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	death e atter	iciai	in the past 12 months?	4☐Pregn	oirth 2□Feta ant at time of d		∃Ectopic pregnanc ∃ Other <i>(sp</i> ec <i>ify)</i> _	у				lonth	Day Year
P.0	that the de sed by the a detached t	hys	9 Unknown	9□Unkno	own					1			
	es igr	by	Part II. Other significant cond	ditions contributing to de	eath but not res	sulting in the u	nderlying cause giv	en in Part I.					he cause of death?
Vital Records,		Completed								, U'	∕es 2□No	3 Pro	bably 4, winknown
3ec	2 8 2	mple								24a. Was		Were auto prior to co death?	opsy findings available empletion of cause of
a	(0 ===	e Co	25. Was case referred to med	ical						1□ Yes	2 □ No	1 ☐ Yes	2 No
-	Physiclan: r this certific ral director,	To Be	examiner?	Hospital:	npatient 2	ER/Outpatier	nt 3 DOA Oth	oor.	of Death	(Check only o	<i>ne)</i> dence 6 ⊟Ot	her (Speci	f ₄)
٥	ting Phys After this funeral di		27. Mann of Death	28a. Date		28b. Time o					now injury occu		97
Sio	Attending r death. ector: After by the fune	atio	Z L Acoident	estigation	in, Day Tour	Injury		Yes 2 □!	No				
Division	after de Direct Jin by t	Certification:			of injury · At h ng, etc. <i>(Sp</i> ec <i>i</i>		reet, factory, office		28	8f. Location (S City or Tov		ber or Run	al Route Number,
	ospital hours a uneral I ly filled		29a. Certifier 1 Certifi	fying Physician: To the	hest of my kno	wledge deat	h occurred at the ti	me date an	nd place, a	nd due to the	cause(s) and n	nanner as s	tated
	1 4 T 5	Medical		cal Examiner: On the b									
	To the within To the Comple	Me	29b. Signature and title of cert	ifier			29c. Licens	se number			29d. Date sign	ed (Month,	Day, Year)
			100	el Do		DY	17	15	73	4	10.	11:	07
	(01)		30. Name and address of pers	on who completed cau	e of death (Iter	m 23a) (Type,	Print)	71	2 1	1	Λ	0	NI MD
	01		31. Date filed (Month, Day, Ye	MIN	egistrar's Sign	An Andrews	(1)	550	16	al to	rnHV	160	ELHO 2130
	Sta Registr		OCT 1		us D	1408	age.						

Division or Vital Records. P.O. Box 68760. LEONA MAGAZINER

	-	1 - State of N	/laryland / Do (epartment of H Certificate of I	lealth and M <i>Death</i>	lental Hygid Reg	ene 2007	33021	
Physicia /Medic		Decedent's Name (First, Middle, Last) LEONA		MAGAZINER		2. Date of Death Month OCTOBER	Day 2007	3. Time of Death 8:00A M	
Examin		4a. Facility Name (If not institution, give street and number STELLA MARIS HOSPICE	<u> </u>		TIMONIU		4c. County of Death	BALTIMORE	
Funeral Director		5. Social Security Number 219-01-8943 Usual Residence of Decedent	Age (In yrs. last birth	day) If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month Day 1)	9. Birth Con	nplace (State or Foreign untry) MA	
ne Maryland 8a-f show ptifled at	Director	10a. State 10b. County MD BALTIMORE	10c. City, Town	S MILLS				10d. Inside City Limits 1 ☐ Yes 2 No	
ath with the 23a or 2 ust be no	ral Dire	3420 ASSOCIATED WAY, #40			1117		g. Citizen of What Cou USA		
filed within 72 hours after death with the Maryland Hygiene Hygiene With I watural", or items 23a or 28a-f show ant, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 ☒ Married 3 □ Widowed 4 □ Divorced 12. Was Decede Armed Force 1 □ Yes 2 ☐ If Yes, Give Year or Date:	s? (j No	13. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 🕅 No	ispanic Origin? (Spe an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White Specify: W		
d within 72 ho giene. rr than "natui the Medical	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4c)	(Decedent's Usual Occup Give kind of work done of life. DO NOT use retired HOMEMAKE	during most of worki d)	ng 1	6b. Kind of Business/I	•	
is and 2 should be filed within of Health and Mental Hygiene. If item 27 is marked other than in other traumatic event, the Me	To Be C	17. Father's Name (First, Middle, Last) BENJAMIN	40)	MUSKIN	18. Mother's Name		Ĺ	INSKEY	
1 and 2 sh Health and tem 27 is n		19a. Informant's Name/Relationship (Type. Print) LEON MAGAZINER / HUSBAND 20a. Method of Disposition	34	Mailing Address (Street of ASSOCIAT Disposition (Name of crematory or other place)	ED WAY, #	401, OWI		, MD 21117	
permit. Pages: Department of Important: If ite any injury or of		1 (X Burial 2 □ Cremation 3 □ Removal from Sta 4 □ Donation 5 □ Other (Specify) 21. Signature Funeral Sergico Licer, ee		MORE HEBREW 22. Name and Addres	10/14	/2007	REISTERSTO	OWN, MD	
perm Depa Impo any i	9 9	23a. Part1. Enter the disease, or complications that caus	A Dans	8900 REIS	STERSTOWN	ROAD - F	ON & BROS	, MD 21208	
Physician /	Ö 1	shock, or heart failure. List only one cause on each immediate Cause (Final disease or condition resulting in death)	OVASCULAR	ACCIDENT	ig, such as cardiac c	or respiratory arres	51,	Approximate Interval Between Onset and Death	
ate be executed many sician and the burial-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	as a consequence of as a consequence of as a consequence of):					
The law requires that the death certific the has been signed by the attending page 2 should be detached for use as the state of the same as the same a	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown 23c. If yes, outcor 1 □ Live birth 4 □ Pregnant 9 □ Unknown	very Day Year						
uires that signed by d be deta	þ	Part II. Other significant conditions contributing to death	but not resulting in t	he underlying cause give	en in Part I.		acco use contribute to		
The law requir cate has been si page 2 should	Completed								
hysician: Th his certificate I director, pag	To Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpa	atient 2 ER/Outp	patient 3 DOA Oth	26. Place of Deather: 4 □ Nursing Ho		nce 6 X IOther (Spec	eify) HOSPICE	
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifics completely filled in by the funeral director, p	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of	Day Year) Inj	ury Wor	Yes 2 □ No	28d. Describe hov 28f. Location (Stre City or Town,	eet and Number or Ru	iral Route Number,	
e Hospital 124 hours a e Funeral I letely filled	Medical Ce	29a. Certifier (Check only one) 1 Certifying Physician: To the beside the property of the desired manner and	of examination and						
To the within to the comp	Me	29b. Signature and title of certifier		29c. Licens	e number 4372		d. Date signed (Mont)		
3		30. Name and address of person who completed cause of DR. TARIQ MAHMOOD 2300	f de <i>a</i> th (Item 23a) (T		TIMONIUM,	MD 2109	3		
Sta Registr	_		strar's Signature	1 - W -					
DHMH 17 Rev 1/20	001	20120 2001 1 939	ms for	RIGINAL					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

MUCRER, WILLIAM

				Type or Print					_	le.
		•	1 - For Amend Item 2	o per me,g	8/2,10/16/	rtificate of	Death	F	Reg. No. 2 1	77 22022
	Will St		Decedent's Name (First, Middle, La					2. Date of Dea	ıth C	3. Time of Death
	Physici /Medic		William Moore	r				AUGUST		007 2358 PM
	Examir		4a. Facility Name (If not institution, give	e street and number)		4b. City, Town, o	r Location of Dea	ath	4c. County of	Death
				MIALITY	Hespital	BACTI				
H	Funeral Director			Sex 7/1 Age	(In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hr Hours Mir		1935	9. Birthplace (State or Foreign Country) unk
	P ,		Usual Residence of Decedent 10a. State 10b. County		10c. City. Town or Lo	ocation	-			10d. Inside City Limits
	aryla shov	5	MD Baltimo		Balti					1 □ Yes 2√∑ No
	the M 28a-f cotifie	ect	10e. Street and Number		Daici	10f. Zip Code			10g. Citizen of Wh	11
	a or	Funeral Director	2000 McKinnon La	na		Tor. Zip code	2122			•
	eath	era	11. Marital Status unk	12. Was Decedent E Armed Forces?	ver in U.Sun la 13.	Was Decedent of H		_	US. 14. Race -	A - American Indian,
36	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 28a-f show int, the Medical Examiner must be notified at		1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced	Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		If Yes, specify Cub 1 ☐ Yes 2 No	an', Mexican', Pue Specify:	erto Rićan, etc.)		White, etc. White
0 P	tura cai E	Pe	15. Decedent's E	ducation	16a. Dece	dent's Usual Occup	pation	unk	16b. Kind of Busi	ness/Industry un
21215-0036	hin 7% In "n Medi	Completed by	(Specify only highest grant Elementary/Secondary (0-12)	ade completed) College (1-4or 5+	life	kind of work done DO NOT use retire	during most of w d)	orking		
21	d withir giene. er than the Me	E O		unk	<u></u>					
Maryland	be do la do	To Be (17. Father's Name (First, Middle, Last	")		unk	18. Mother's N	ame (First, Middle,	Maiden Surname	unk unk
ary	0, =		19a. Informant's Name/Relationship	(Type. Print)	19b. Maili	ng Address (Street	and Number or i	Rural Route Numbe	er, City or Town, S	tate, Zip Code)
	and 2 ealth a n 27 is		University Specia	ality Hospi	tal 601	l S. Char	les Stre	et Balti	more, MD	21230
Baltimore,	Page: ento nt: If i		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☒ Other (Speci		20b. Place of Dispo cemetery, cre	osition (Name of ematory or other pla	ce)	Date	20c. Location - C	ity or Town, State
Balti	permit. Pag Department important: any injury once,		21. Signature a Funeral Septce Lice ROna S.				-		Baltimo	re Street
	-		23a. Part1 Enter the disease, or con shock or heart failure. List only	polications that caused t		altimore, ter the mode of dyi			rest,	Approximate Interval Between
	Physician	8.	Immediate Quise (Final	one cause on each line	7	/	mami			Onset and Death
	/Medical		disease or consilion resulting in death)	a.	consequence of):	0 0 10	101201000	2.2		
10	Examiner			PERMI		EGE TAK	TUE	81179		.1110'
J.		Je	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a	consequence of):	/		1/	mpa	
	executed n and ial-transit	Examine	Cause (Disease or injury that initiated events	c. HTPG	JU LENS 12	\sim			BY MEDICAL EXPANSION	
o,			resulting in death) Last		consequence of):	N	/	CHTY APPROVED	34 Miles	
09289	ficate be e physiciar s the buria	ical		d. 81 AB	ETED	NEWIT	W)	CHANA		
39	ing ph	Med	IF FEMALE:	0.			CEL	THE STATE OF THE S	- P 2 - N2	
.O. Box	The law requires that the death certificate be ate has been signed by the attending physicia bage 2 should be detached for use as the bur	Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome p 1 □ Live birth 2 4 □ Pregnant at t 9 □ Unknown	Fetal death 3	⊒Ectopic pregnand ⊒ Other <i>(specify)</i> _	у		23d. Date Mont	,
Δ.	that the		Part II. Other significant conditions	contributing to death bu	not resulting in the u	underlying cause giv	ven in Part I.	23e. Did to	obacco use contrib	oute to the cause of death?
ds,	signe d be	l by	Hyps TH Romin	n		, , ,		1 🗆 1	/es 2 No 3	B ☐ Probably 4 ☐ Unknown
Records,	w require been si should b	Completed	FRH 20 PHRENIA					04- 18/0-	O4h 144	are automorphism or available
3ec	The law cate has I page 2 s	ldm						24a. Was autop	an 24b. w osy pri rmed? de	ere autopsy findings available ior to completion of cause of eath?
a	iclan: Th certificate rector, pag		30100,00	1 sonoch_				1□ Yes	2□No 1L	☐Yes 2☐ No
Vital	Physician: this certificatal director, p	Be	25. Was case referred to medical examiner?	Hospital:		-t all post oth	nor:	eath (Check only o		
ō	Physral di	. To	1 ★ Yes 2 N o 27. Manner of Death	28a. Date of Injury	t 2 ER/Outpatie	III 3 DOA	4 LI Nursing	Home 5 ☐ Resid	dence 6 LOther now injury occurred	
on	ding h. After funer	ţi	1-☐ Natural 5 ☐ Pending investigation	(Month, Day	Year) Injury	Wo	rk?]Yes 2∐No			
Division	l or Attending after death. Director: After in by the funer	Certification:	3 Suicide 6 Could not be determined	e 280 Place of injur	y - At home, farm, st (Specify)			28f. Location (S City or Tov		r or Rural Route Number,
-	Hospita 24 hours Funeral	edical Co		hysician: To the best o miner: On the basis of and manner stat	examination and/or in					
	To the within To the Comple	Med	29b. Signature and title of certifier	and marrier state		29c. Licens			29d. Date signed	(Month, Day, Year)
						1 10	72911	4.2		

State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

TAND (ANDA) 300 ARROW BLA 31. Date filed (Month, Day, Year)

OCT 1 6 2007 32. Registrar's Signature

29c. License number
9 (1) 56 9 4 8

SHITE SH, BAGIAME

			For State Registrar	tate of Maryland	Certificate			ygiene Reg. No.	2007	3302
	Physici /Medic		Decedent's Name (First, Middle, Last) EFROIM		MEYEF	ROV	2. Date of D Month OCTOBE	R Day	2007	3. Time of Death 2:17Å M
	Examir		4a. Facility Name (If not institution, give stree 1121 SILENTGLADE R			WN, or Location			County of Death BALTIMOI	RE
	Funeral Director		5. Social Security Number 217-25-5445 6. Sex	2□F 7. Age (In yrs. Ia 94	st birthday) If Under 1 \ Yrs. Months D	ear If Under lays Hours	24 Hrs. 8. Date of E (Month, 1)	orth (2ay) 1913	9. Birthp Cour	olace (State or Foreign OKRAINE
	Maryland f show led at	tor	Usual Residence of Decedent 10a. State 10b. County MD BALTIMORE		Town or Location INGS MILLS				1	0d. Inside City Limits 1 ☐ Yes 2 \ No
	3a or 28a- st be notif	al Direc	10e. Street and Number 1121 SILENTGLADE R		10f. Zip Co	21117	7	10g. Citiz	ten of What Cour	ıtry?
980	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 Is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	t by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☒ Married	Nas Decedent Ever in U.S Armed Forces? I ∐Yes 2 X No f Yes, Give ⁄ear or Dates:	. 13. Was Deceden If Yes, specify	t of Hispanic Or Cuban, Mexica	igin? (Specify Yes or f n, Puerto Rican, etc.)		4. Race - Americ Black, White, Specify:	
1215-0	/ithin 72 ho ne. han "natu e Medical	Completed	15. Decedent's Education (Specify only highest grade co	mpleted) College (1-4or 5+)	16a. Decedent's Usual C (Give kind of work of life. DO NOT use if	done during mos retired)	st of working	16b. Kin	BEAUTY	dustry
Maryland 21215-0036	uld be filed v Mental Hygie Irked other t rtic event, th	To Be Co	17. Father's Name (First, Middle, Last) BORIS	4	MEYEROV		er's Name <i>(First, Mida</i> CHAMA	le, Maiden S	Surname)	BTAINABLE
	and 2 should ealth and Men n 27 Is marke her traumatic	•	19a. Informant's Name/Relationship (Type. FENYA MEYEROV / WI	FE		NTGLADE	ROAD. OWII	NGS MI	LLS, MD	21117
Baltimore,	permit. Pages 1 and 3 Department of Health Important: If item 27 any injury or other tr		20a. Method of Disposition 1		ace of Disposition (Name of metery, crematory or othe TIMORE HEBRI	EW :	Date 10/15/2007		STERSTOW	
Balt	permit Depart Import any in		21. Signature of Funeral Service Licensee			EISTERS	TOWN ROAD	- PIKE	& BROS. ESVILLE,	MD 21208
	Physician /Medical		23a. Part1. Enter the disease, or complicating shock, or heart failure. List only one commediate Cause (Final disease or condition resulting in death)	ons that caused the death. ause on each line. Liver feilur Due to (or as a conseque	و	f dying, such as	s cardiac or respiratory	arrest,	1	Approximate Interval Between Onset and Death Adays
	Examiner	Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c		colorectal conce					Zyeurs
30,	ificate be executed g physician and as the burial-transit	I Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conseque	ence of):					
P.O. Box 68760,	ath cert ttendin or use	Physician/Medical	in the past 12 months?	f yes, outcome pf pregnan 1∐Live birth 2∏Fetal (4∏Pregnant at time of dea 9∏Unknown	death 3 ☐ Ectopic pregi			. 2	3d. Date of delive	ery Day Year
	luires that the de n signed by the a lid be detached f	þ	Part II. Other significant conditions contrib	uting to death but not result	ting in the underlying caus	se given in Part I				he cause of death?
Il Recoi	The law require ate has been sig page 2 should b	Completed					24a. Wa au pe 1 Yes	topsy rformed?	24b. Were auto prior to co death? 1 ☐ Yes	ppsy findings available mpletion of cause of 2 □ No
Division or Vital Records,	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate hat completely filled in by the funeral director, page	Certification: To Be (1 Matural 5 ☐ Pending investigation	I □ Inpatient 2 □ E	M Mne, farm, street, factory, o	Other: 4 Nu Injury at Work? 1 Yes 2	28f. Location	sidence 6 e how injury		
	To the Hospital or A within 24 hours after To the Funeral Direct Completely filled in b	Medical Ce		n: To the best of my know On the basis of examination						
	To the within To the comple	Med	29b. Signature and title of certifier			20604			e signed (Month,	Day, Year)
	27		30. Name and address of person who compl	eted cause of death (Item		, 4d 2K93				
.7	Sta Registi		31. Date filed (Month, Day, Year) OCT 1 6 2007	32. Registrar's Signatu	Appendix					
DH	MH 17 Rev 1/2	001			6					

		For State Registrar	State	of Mary	land / Depa	artment o rtificate	of He	ealth ai <i>eath</i>	nd M		giene Reg. No.		7	33	024
Physici	an	1. Decedent's Name (First, Middle Hyacinth M. Malo								2. Date of De Month October	ath Day	007	Year	3. Time 7:55	of Death
/Medio Examin		4a. Facility Name (If not institution		umber)		4b. City, To	wn, or l	Location of				County of	Death		
		Morningside House				Laurel		If I bed as O	4.11==			rince			
Funeral Director		5. Social Security Number 027-24-9032	6. Sex 1 □ M 2 1 F	7. Age (In	yrs. last birthday) 5 Yrs.	If Under 1 Months E	Days	If Under 24 Hours	Min.	8. Date of Bird (Month, Da October	th 19, Yea <i>r)</i> 22,	1922	9. Birthp Coun Jama i	ıtrv)	e or Foreign
pu ,		Usual Residence of Decedent		10	o Ciby Town or La	ontion								Od Incide	City Limite
arylar show	占	10a. State 10b. County	Georges		c. City, Town or Lo	cation							'		City Limits es 2 No
the M 28a-f notifie	recto	Maryland Prince 10e. Street and Number			aurel	10f. Zip C	ode				10a. Citi	zen of Wh	nat Cour		
3a or	Funeral Director	7700 Cherry Lane				20707					USA				
death	ner	11. Marital Status	12. Was De	cedent Ever	in U.S. 13.	Was Deceder	nt of His	spanic Origi	in? (Spe	cify Yes or No Rican, etc.))-	14. Race	- Americ		
paritimore, Invaryiating ZIZI3-0030 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any hiptry or other traumatic event, the Medical Examiner must be notified at once.	by Fu	1 ☑ Never Married 2 ☑ Marr 3 ☑ Widowed 4 ☑ Divorced		2 🐧 No aive		1 ☐ Yes 2	,	Specify:	T delle I	noari, etc.)		Specify:			
2 hou		15. Deceden	's Education		16a. Dece	dent's Usual (Occupa	tion			16b. Ki	nd of Busi	iness/Inc	dustry	
thin 72 te.	Completed	(Specify only higher Elementary/Secondary (0-12)		(1-4or 5+)	life.	kind of work DO NOT use	retired)	uring most o	ot workir	ng III					
led wi fygien her th		47 Fallanda Nama (Sinak Middle	2		Book B	inder an				(Finat Atiotala		olishi			
d be fi	Be c	17. Father's Name (First, Middle,	Last)							(First, Middle,	, iviaideri	Surname,	,		
should Me mark imatic	မ	Vernon Coombs 19a. Informant's Name/Relations	nip (Type. Print)		19b. Mailii	ng Address (S	Street a			'erpool I Route Numb	er, City o	or Town, S	tate, Zir	Code)	
INTO 2 salth ar 27 is or trau		Rosemary Malcolm-	daughter		7405	Double R	Rock	Ct	Laure	1, MD 20	707				
es 1 a of Hear rothe		20a. Method of Disposition 1) Burial 2 □ Cremation		I	Ob. Place of Dispo	sition (Name	of	1		ate		ocation - C	ity or To	wn, State	
Pag ment ant: I		4 □ Donation 5 □ Other (S	pecify)	i State	Lakemont (Cemetery	<u>'</u>	10	/15/2	2007	David	dsonvi	lle,	Maryl	and
Dalling Dermit. Pages Department of mportant: If i any Injury or o		21. Signature of Funeral Sarvice	Licensee	34		2. Name and A leck Fun		-							
_ 60260	Н	23a Part1 Enter the disease, or	complications that	caused the	death. Do not en	601 Sand	ly Sp	ring R	d., 1	aurel, N	1D 207	707		Approxin	nate
Dhominin	10	23a. Part1. Enter the disease, or shock, or heart failure. List	only one cause on	each line.	. III And I	()	or dying	, 00011 00 0	ardido o	r respiratory a				Interval E Onset ar	Betwe <i>e</i> n
Physician /Medical		disease or condition resulting in death) Due to jor as a ignsequence of:											1	w	
Examiner		Doe to or as a possequence of: Quellation													
D #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or injury	1	1	14 0	. ,)									
ecute and I-trans	Examiner	that initiated events resulting in death) Last	c	Mon	nsequence of):	rem	0	Wal	w				+		
cate be executed physician and the burial-transit	alE			7 (01 45 4 00	U solo oi,										
oo/ ifficate g phys	edical		a				***								
th cert	M/ne	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, o]Ectopic preg	onancy				1	23d. Date		-	V
he dear the att	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		gnant at time		Other (spec						Mont	n	Day	Year
that the hold by		Part II. Other significant condition	ns contributing to	death but no	ot resulting in the u	nderlying cau	ise give	n in Part I.		23e. Did t	tobacco u	use contrib	oute to ti	he cause o	of death?
w requires to been signer should be o	q pe	gastrain	ejua	V VI	nuan	<u> </u>				1 🗆	Yes 2	□ No 3	3 ☐ Prob	bably 4	Unknown
law re as bee 2 sho	Completed by	8				0				24a. Was		24b. W	ere auto	psy findin	gs available of cause of
The ate his page	Com									perfo	ormed? 2 \(\) No	de	eath?	2∐ No	7 00000 01
vital ician: ector, p	Be	25. Was case referred to medica examiner?	Hospital:					_	of Death	(Check only o	one)				
Phys rthis c	-1 1	1 Yes 2 No 27. Manner of Death	1 ' 1	Inpatient e of Injury	2 ER/Outpatier		Othe	4 LI NUR		ne 5 Resi		6 Other		5/A/SS	15151)
ding Phy th. : After thi e funeral o	tion	1 ☐ Natural 5 ☐ Pendin 2 ☐ Accident investig	g (Mo	onth, Day Ye		м	c. Injury Work' 1 □ Y	? ′es 2 ∐ N	ŀ	ou. Boomso	now injui	y odourre	u	L	101111
Atter Tector by the	Certification:	3 ☐ Suicide 6 ☐ Could in determ	not be ined 28e. Plac	ce of injury -	At home, farm, str Specify)	eet, factory, o	office		2	28f. Location (Street an	nd Number	r or Rura	al Route N	lumber,
ital or ral Din Bled in	Cert			dirig, oto. (0						ony or 70	ini, oldic	·/ 			
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	edical		g Physician: To the Examiner: On the and ma		amination and/or in										se(s)
To the within To the Complete	Me	29b. Signature and title of certifie	0.	1 -		29c.L	License	number			29d. Da	te signed	(Month,	Day, Year	r)
-		Manie	Ce WY	dyo		$ \mathcal{D} $	10	752	3	,	1	0/8	1201	y/_	
68		30. Name and address of person	who completed cal	use of death	(Item 29a) (Type,	Print)	n	Ruc	ud	#32	v G	une	4/	hd.	
Sta	ate	31. Date filed (Month, Day, Year)	32,	Begistrar's	Signature								20	101	/
Registi	rar	OCT 1 6	2007	Estable of	H do	and D								/	

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 11:25 PM **Physician** Agatha Elizabeth McFaul **OCTOBER** iż. 2007 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Towson Baltimore Center Saint Joseph Medical 9. Birthplace (State or Foreign Country)
MD If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 12/12/1919 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours Min. 213-12-0965 1 □ M 2 []XF Director 87 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County r 28a-f show notified at 1 ☐ Yes 2√2 No Director Overlea MD Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code "natural", or items 23a or USA 21206 A Glenmore Ave Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Specify: White 1 ☐ Yes 2 ☐ XNo Baltimore, Maryland 21215-0036 þ 3 → Widowed 4 Divorced Completed r than "natur the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Telephone Company Telephone Operator item 27 is marked other other traumatic event, tl 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be and Mental Alumina Schutte ၀ George J. Hahn 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1 A Glenmore Ave Baltimore, MD 21206 19a. Informant's Name/Relationship (Type. Print) of Health a Joan Gebhardt-Daughter Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Department of Important: If it any injury or o once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Timonium, MD Dulaney Valley Cem. 10/17/07 22. Name and Address of Facility Miller-Dippel Funeral Home, Inc. 21. Signature of Fundal Service Licensee 6415 Belair Rd Baltimore, MD 21206 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cau. Final disease or condition resulting in death)

a. RESPIRATORY FAILURE Approximate Interval Between Onset and Death 28 DAYS **Physician** /Medical Due to (or as a consequence of): **Examiner** BILATERAL PNEUMONIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760. PANCREATIC CARCINOMA burial-tran Due to (or as a consequence of): Physician/Medical attending properties of the second IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 9☐Unknown 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2⊠No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? certificate 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 2 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3□ DOA Certification: To this funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 5 ☐ Pending investigation Injury 1 Natural 1 ☐ Yes 2 ☐ No Director: / 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide in 24 hours the Funeral Directory filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only within 24 and manner stated. 29d. Date signed (Menth, Day, Year) 29b. Signature and title of certifier 29c. License number D 26954 7 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DRIVE, TOWSON, MARYLAND 21204 7671 OSLER DEMY CHHIM M. D 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registrar OCT

			Please	Type or Prin							egible.	
		1	For State Registrar	State of Ma	aryland		tificate of			Reg. No.	2007	33026
Phys /Me		n il -		liam Nov	ak				2. Date of Dea Month Octobe	Day		3. Time of Death 10:00A M
Exam	nine	r	4a. Facility Name (If not institution, give Stella Maris H					r Location of Death imonium		4c. C	ounty of Death Balti	more
Funer Directo			5. Social Security Number 6. S		e (In yrs. last	t <i>birthday)</i> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Day Aug. 27	y, Yea <i>r</i>)	9. Birthp	lace (State or Foreign
Maryland f show led at			Usual Residence of Decedent 10a. State 10b. County Maryland Ba1	timore	10c. City, T	own or Lo	oation Overlea	-			1	0d. Inside City Limits 1 ☐Yes 2M No
th the or 28a		# . ⊢	10e. Street and Number	CIMOLE	ļ		10f. Zip Code	1		10g. Citize	n of What Cour	ntry?
ath wi			11 Walnut Avenue	T		1		1206			J. S. A.	
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at		2	11. Marital Status 1 □ Never Married 2 X Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Armed Forces? 1 M Yes 2 1 If Yes, Give Year or Dates:		-	Was Decedent of H fYes, specify Cuba I∐Yes 2 🎇 No	lispanic Origin? (Span, Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)		Black, White,	
5-00 72 hou 'natura dical E		Completed by	15. Decedent's Ec			16a. Deced	lent's Usual Occup	eation during most of work d)	king	16b. Kind	of Business/Inc	dustry
within ene.		E C	Elementary/Secondary (0-12)	College (1-4or 5	i+)	life. l	NOT use retired Mechani			II S	Postal	Service
other vent, ti	1	ne Pe	17. Father's Name (First, Middle, Last))			TICCHAIL	18. Mother's Nam	e (First, Middle,			
ylar ylar ould be Menta arked attc ev		0 .	William Nova						clotte W			
Mar d 2 sho d 2 sho th and 7 Is m traum		1	19a. Informant's Name/Relationship (and Number or Ru enue, Ove				
s 1 an f Heal item 2		-	Lillian Josephine 20a. Method of Disposition		20b. Plac	e of Dispo	sition (Name of matory or other place	i	Date Date		ition - City or To	
Page ment c ant: If ury or			1 ☐ Burial 2 【X Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif			iew (Crematory	10/13				faryland
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours aft pepartment of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural"; or any Injury or other traumatic event, the Medical Exami	ouce.		21. Signature of Funeral Service Licer	ull		97	705 Belai	ss of Facility Sch r Rd., No	ottingha	am, Ma		
te be executed Examine Asician and the burial-transit	al er	Ĭ,	23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. CONGEST Due to (or as b. Due to (or as c. Due to (or as	a consequer	ART F nce of):		g, sauri ao sarata	o. copilatory a		2.1	Approximate Interval Between Onset and Death
I Records, P.O. Box 6871 The law requires that the death certificate to the has been signed by the attending physicage 2 should be detached for use as the to the total the total the total the total the total total the total the total total the total the total tot		/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Fetal de	eath 3	Ectopic pregnanc	y		23	d. Date of delive	ery Day Year
cords, P. w requires that s been signed b s should be deta	Ι.	2	Part II. Other significant conditions of	contributing to death b	ut not resultir	ng in the u	nderlying cause giv	en in Part I.			e contribute to the	he cause of death?
or Vital Recol Physician: The law rec r this certificate has beel rail director, page 2 shou		Completed							24a. Was autop perfo 1∐ Yes		prior to co death?	psy findings available mpletion of cause of 2 No
Vite sician: certific rector,		g Q	25. Was case referred to medical examiner?	Hospital:		VO. 1-1	nt 3 DOA Oth	26. Place of Dea			-	
Vision Attending r death. ector: Afte	;	Certification: 10	1 Yes 2 No 27. Manner of Death 1 No Natural 2 Accident 3 Suicide 4 Homicide 2 No Could not be determined	28a. Date of Inju (Month, Da	y Year)	3b. Time o Injury	f 28c. Injui	4 Li Nuising n	28d. Describe	how injury	occurred	y) HOSPICE al Route Number,
Hospita 4 hours Funeral		Medical Cer		nysician: To the best miner: On the basis of and manner st	f examination							
To the within 2 To the complet	:	Mec	29b. Signature and title of certifier	and mariner st	ated.		29c. Licens	e number		29d. Date	signed (Month,	Day, Year)
->-0				1			D	4372	^	1	10/12/0	7
3			30. Name and address of person who DR. TARIQ MAHMOO				Print)	TIMONIUM,				
Regi	Stat stra		31. Date filed (Month, Day, Year) OCT 1 6 2	29.7	ar's Signatur		and of					

from

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiens, 33027 Rag. No. Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Year 3:49 AM **Physician** rarles 2007 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Samaritan Baltimore Hospital If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 6. Sex 5. Social Security Number **Funeral** 1**/2**M 2□F Months Days Hours January 24, 1921 Maryland Director 213-14-8528 Usual Residence of Decedent 10d. Inside City Limité 10c. City, Town or Location 10b. County 10a. State ? is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinar must be motified at Parkville 1 ☐ Yes 2 Z No Baltimore Maryland Director 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number United States Of America 21234 2526 Windsor Road Funerai 12. Was Decedent Ever in U.S. Armed Forces 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. 1 ☐ Never Married 2 ☐ Married Specify: White 1 ☐ Yes 2 Z No Specify: 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry trester, charles 15. Decedent's Education permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "na any injury or other traumatic event, the Madic 2006. (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Joseph A. Bank Accountant 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Annie Perry David Preston 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 8815 Littlewood Road, Baltimore, MD, 21234 Mark Preston - Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Oct. 18,2007 Parkville, Maryland Moreland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility EVANS FUNERAL CHAPEL & CREMATION SERVICES 8800 Harford Road, Parkville MD, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) One week Physician Seps,s /Medical Due to (or as a consequence of) Examiner week ue to (or as a con-equence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medicai IF FEMALE: 23d. Date of delivery 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ 2 No 3 ☐ Probably 4 ☐ Unknown 1 Tyes Pibrillation Chronic obstructive Be Completed 24b. Were autopsy findings available prior to completion of cause of death? Was autopsy performed? 24a. Was an Vascular differ MRSA or this certificate has 1 Yes 2 No 1☐ Yes 26. Place of Death (Check only one) 25. Was case referred to medical examiner' Hospital: 1 Inpatient Other: 4 Nursing Home 1 ☐ Yes 2 ☑ No 5 ☐ Residence 6 ☐ Other (Specify) 2 ER/Outpatient 3 DOA ٩ After thi 28d. Describe how injury occurred Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death Certification: 5 Pending Matural 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after death To the Funeral Director: , completely filled in by the f 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar

KAZORY, 5601 31. Date filed (Month, Day, Year) OCT 1 6 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Loch Raven Blvd, Baltimore, MD 21239 32. Registrar's Signature

M.D.

RES-000

10/15/2007

State Registrar

7601 JOGINDER P MEHTA. M. D.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

OSLER DRIVE TOWSON. 32. Registrar's Signature 31. Date filed (Month, Day, Year)

Mehla mo

29b. Signature and title of certifier

ORIGINAL

29c. License number

D0041410

29d. Date signed (Month, Day, Year)

MARYLAND 21204

2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Year Month **Physician** Pfanstie1 Brenda Μ. OCTOBER 200 10 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner ARUNDEL WASHINGTON MEDICAL GUEN BU URNIE BALTIMORE ANNE 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1 ☐ M 2 🗓 F 268-40-8770 Director June 22, 63 1944 OH Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County Anne Arundel 1 ☐ Yes 2 X No r 28a-f sh notified Director Glen Burnie 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code a or 707 Hyde Park Drive 21061 USA r than "natural", or items 23a the M di-al Examiner must t Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian. 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after. Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or iten any injury or other traumatic event. the Markel Eventing 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: white <u>ک</u> 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William Eleanor May Hershberger ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 707 Hyde Park Dr. Glen Burnie MD 21061 Mr. Roger Pfanstiel/husband 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 10/15/2007 Crownsville MD MD Veterans Cemetery 22. Name and Address of Facility 21. Signature of Funeral Service Licens 22. Name and Address of Facility Singleton Funeral & Cremation 1 2nd Ave SW Glen Burnie MD 21061 M01364 Srvc Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) MONAR **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, it and today to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to or as a consequence of Examine The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of) Physician/Medical attending ph IF FEMALE 23c. If yes, outcome pf pregnancy 1□Live birth 2□ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š 1 Yes 2 No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform certificate Be (25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 1 Inpatient 2 this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide

Division or Vital Records, P.O. Box 68760

HRENDA

PANSTIEL

To the Hospital or Attending Physician: within 24 hours after con-

Medical 20 State Registrar

29b. Signature and title of certifier

29a Certifier

29c. License number

1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ONASAD 301 HOCP, TAL DRIVE JABAID

and manner stated.

GLEW BURNIE MD DOLL

32. Registrar's Signature 31. Date filed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene 2 1 1 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month OCTOBER **Physician** 2007 PAULINE VERA QURESHI 9:30 аМ /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner LAUREL REGIONAL HOSPITAL LAUREL PRINCE GEORGE'S If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 □ M 018-38-4524 Sept 20, 1946 61 Massachusetts Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City, Town or Location r 28a-f show notified at 10a. State 10b. County 1∏Yes 2∏No Directo Prince George's Maryland Laurel 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ral", or Items 23a or 2 Examiner must be n 7668 E. Arbory Court 20707 U.S.A. Pages 1 and 2 should be filed within 72 hours after death went of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or Items 23.
Iny or other traumatic event, the Medical Examiner must Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🏋 🚜o If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 🗓 No Specify ģ White 3 ☐ Widowed 4 🔀 X ivorced Year or Dates Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) years Teacher/Instructor Day Care 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ronald Wood, Sr. Pauline Crawford 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2: Department of Health a Important: If item 27 Is any Injury or other trav Charles Biggs /Friend 7668 E. Arbory Court Laurel, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 10/12/2007 West Arundel Crem. Odenton, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Sen 22. Name and Address of Facility Donaldson Funeral Home, P.A. 313 Talbott Avenue Laurel, Maryland 20707 / M00770 23a. Part1. Enter the disease, of shock, or heart failure. Lis complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Myocardial Infarction **Physician** disease or condition resulting in death) /Medicai Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. End Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): The law requires that the death certificate be executed Exam physician and s the burial-tran Due to (or as a consequence of) P.O. Box 68760. Physician/Medical attending for use as IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 5 Other (specify) signed by the a d be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ Cerebrovascular Accident 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed Neurogenic Bladder 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes YNo 24a. Was an autopsy pertormed? Yes 2 Demyelinating Disease certificate 1☐ Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes ¾XNo 1 Inpatient 2 Noutpatient 3 DOA P 28b. Time of 27. Manner of Death 28a. Date of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: After (Month, Day Year) 5 ☐ Pending investigation XXNatural 1 □ Yes 2 □ No I Director: / 2 Accident 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours aft

To the Funeral Di

completely filled in Extifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) October 11, 2007 D 31528 30. Name and address of person who completed cause of death (Item 28a) (Type, Print)

State Registrar

31. Date filed (Month, Day, Year)

Dr. Akpen

32. Registrar's Signature

6128 Landover Road, Cheverly Hills Medical Center, Cheveraly, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** William Edward DOP M 2007 Doto hel /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner W. Broadva-1 Bel Har ford (gunt-120 8. Date of Birth (Month, Day, Dec 25, 5. Social Security Number Birthplace (State or Foreign Country) Age (In yrs. last birthday) 6. Sex **Funeral** Months Hours Days 1**M**M 2□F 68 218-36-6594 Dec 1938 Director Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Harford County Bel Air Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code United States 120 W 21014 by Funeral Pages 1 and 2 should be filed within 72 hours after death anent of Health and Mental Hyglene.
Int: If Hem 27 is marked other than "natural", or items 23.
Int or other traumatic event, the Medical Examiner must any or other traumatic event, the Medical Examiner must Was Decedent Ever in U.S. Armed Forces? 1 Mayes 2 No If Yes, Give Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11, Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 📉 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: Specify: White 3 □ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Supervisor of Information Systems 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Catherine William E. Russell Miller 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Apt J. Bel Air, Maryland 21014 Mrs. Margaret Russell (wife) 120 W. Brondway 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Department of F Important: If ite any injury or ot once. 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Evans Funeral Chapel Oct. 18, 2007 Forest Hill, Maryland 21. Signature of Funeral Service Licensee

22. Name and Address of Facility

23. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximate

Approximate 4 ☐ Donation 5 ☐ Other (Specify) Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) month **Physician** /Medical Due to (or as a consequenc of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence or) Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical attending IF FEMALE: 23c. If yes, outcome pf pregnancy
1☐Live birth 2☐Fetal death
4☐Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 □Ectopic pregnancy Month Year Day 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 ☐ Yes 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed death? 1 ☐ Yes 2□No 1□ Yes 2 1 No 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 ☐ Yes 2 ☐ No after death.

I Director: / 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 [Excertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical

within 24 hours aft **To the Funeral Di** completely filled in

State

29b. Signature ar

39. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Nin (M. D.) 602 South Atwood Road # 200 31. Date filed (Month, Day, Year)

title of certifier

 Registrar's Signature 6 2007

Registrar

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

D45390

29d. Date signed (Month, Day, Year)

October 15th, 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2007 33032 Certificate of Death Rea. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 7.30 A^{M} Ragland October 2007 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner 8700 Reicher St. Hyattsville Prince Georges If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months | Days | Hours | Min. (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Months Days 1 □ M 2 💆 🕏 Yrs. 60 24 1947 Virginia Sept 227-66-3809 Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 28a-f show 1X Yes 2 □ No notified Director MD Prince Georges Hyattsville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Item 27 is marked other than "natural", or Items 23a or other traumatic event, the Medical Examiner must be re 8700 Reicher St 20785 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 14. Race - American Indian. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Black ð 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Clerk Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 should be fi Be Schuler Fannie Robinson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1 and 2 s f Health a 8700 Reicher St. Hyattsville, MD. 20785 Clarence Ragland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Pages 1 permit. Pages 1
Department of H
Important: If ite
any fnjury or ot 1 ☐Burial 2 ☐Cremation 3 ☐Removal from State 4 Donation 5 Dother (Specify) Salem Bap Ch. Cem 10/13/07 King George, VA Todd Drew Cedell Brooks Funeral Hm 22535 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dylng, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Cardiopulmonary Arrest Physician resulting in death) /Medical Due to (or as a consequence of): Examiner Metastatic Breast Cancer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a nonsequence of) Examiner attending physician and for use as the burial-transit Due to (or as a consequence of): Box 68760. certificate be Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 23d Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) led by the a detached f 1 ☐ Yes 2 ☑ No 9 ☐ Unknowr Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Hypertension 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Cervical Disc Disease 24a. Was an autopsy performed? certificate 1□ Yes 2₩ No Attending Physician: in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA r this 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death Certification: (Month, Day Year) Injury 1 Natural 5 Pending Investigation 1 ☐ Yes 2 ☐ No after death. 2 Accident 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 ☐ Homicide 24 hours a Excertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

P.O. Division or Vital Records, Hospital or within 24 ho

To the Function

the

State Registrar

Medical

29c. License number

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

29b. Signature and title of certifier

Name and address of person who completed cause of death (Item 23a) (Type, Print) rving St. N.W. Stc. 3055 Washington DC

Registrar's Signature 31. Date filed (Month, Day, Year,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Manuaged / Department of Health and Mental Hygiene 2007 . County of Death

10/12/07

		_1	For State Of Marylar - State	16/07e	jijicate o	f Death	Reg.	0007	33033
Ph	ıysicia		1. Decedent's Name (First, Middle, Last)		5115	T. 1.1		Day Year	3. Time of Death
1	Medic	al -	SELMA C 4a. Facility Name (If not institution, give street and number)		RUB 4b City Town	Nor Location of Death	OCTOBER 1	L2 2007 4c. County of Dear	12:45 A ^M
E	kamin	er	3310 NERAK ROAD		,,	IMORE		BALTIMOR	
	neral ector		218-01-7894 1 M 2 X 87	. last birthday) Yrs.	If Under 1 Ye Months Da		8. Date of Birth (Month, Day, Ye 01/25/192	9. Bird 20	thplace (State or Foreign ountry) MD
Maryland	notified at		· ·	ity, Town or Loc					10d. Inside City Limits 1 ☐ Yes 2 ☐ No
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0036 hours after death with the Maryland tural!" or Items 23a or 28a-f show	xaminer	by Fur	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in L Armed Forces? 1 X See Show Year or Dates:		rvas Decedento fYes, specify C I□Yes 2∏ I	of Hispanic Origin? (Sp Cuban, Mexican, Puerto No <i>Specify:</i>	Pican, etc.)	Black, Whit	
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Maryland 2 Id 2 should be filed Ith and Mental Hygis 77 is marked other	eve	To Be C	17. Father's Name (First, Middle, Last) WILLIAM	OBE		18. Mother's Nam	e (First, Middle, Mai	den Surname) INKNOWN	
Alary 2 shou and N	. E		19a. Informant's Name/Relationship (Type. Print)		-	eet and Number or Ru		-	
		-	BEVERLY MINDESS / DAUGHTER 20a. Method of Disposition 20b.	I		ΓΑ AVENUE -		c. Location - City or	
O 8 2 =	: b		4 Donation 5 Done (Specify)	Place of Dispo cemetery, cren LTIMORE				EISTERSTO	
Bali permit Depar	any injury once.		21. Signature of Funeral Service Licensee	8	3900 RE	STERSTOWN		KESVILLE	, MD 21208
Physi /Med	dical		23a. Part1. Enter the disease, or complications that caused the dea shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a conse	K:d		dying, such as cardiac	or respiratory arrest		Approximate Interval Between Onset and Death
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Division or Vital Records, othe Hospital or Attending Physician: The law requires to the Europea after death.	in by the fur	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of injury - At 1 building, etc. (Spec	home, farm, str	M	1 ☐ Yes 2 ☐ No	28f. Location (Stree City or Town, S		Rural Route Number,
e Hospital	letely filled	Medical Ce	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my kr 2 Medical Examiner: On the basis of examinand manner stated.	nowledge, deat nation and/or in	h occurred at the	ne time, date and place my opinion, death occu	and due to the causurred at the time, date	se(s) and manner a e and place, and du	as stated. ue to the cause(s)
i i i	E E	Me	29b. Signature and title of certifier		29c. Lic	ense number	29d	. Date signed (Mor	nth, Day, Year)

Name and address of person who completed cause of death (Item 23a) (Type, Print) eath (110m 23a) (Type, Print)
23 Chassroads Dr. Ste#340 Owngs Mills, Md 21117 32 Registrar's Signature 31. Date filed (Month, Day, Year) State 6 2007 Registrar

		1	For State Registrar	State o	f Marylan	d / Depa <i>Cei</i>	artment <i>tificate</i>	of Health of Death	and Me	ental Hyg R	iene 2	007	33034	
	35		Decedent's Name (First, Middle, L.)	ast)						2. Date of Dea Month	th Day	Year	3. Time of Death	
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\partial	/Medic Examin		ta. Facility Name (If not institution, gr				4b. City, To	own, or Location	of Death		4c. Cou	nty ol Death		
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	Funeral		5. Social Security Number 6.	Sex	7. Age (In yrs. I	ast birthday)	If Under 1 Months	Year If Unde Days Hours		8. Date of Birth (Month, Day	Year)	9. Birth	olace (State or Foreign	
ш	Director		292-20-5204	1 ∑ M 2□F	83	Yrs.	NOTA TO	54,0		Sept.20		4	PA	
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	is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 ie marked other than "naturel", or items 23a or 28a-f ehow other transmatic event, it is Medical Examinat must be notified at	_		1	100.00	, ,	olumbia	2					1 ☐ Yes 2 No	
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			shock, or heart lailure. List on Immediate Cause (Final	y one cause on	each line.		/	A 1					Interval Between Onset and Death	
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	thin 2 the I mplet	Medical	one) 29b. Signature and title of certifier	and ma	nner stated.		29c	. License numbe	er .		29d. Date s	igned (Monti	n, Day, Year)	
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	5		30. Name and address of person w		A D	54.50	KAAN	60 Nim	the D	r Su	te 2	60 (5. 2007. Olumbia	
	St	ate	31. Date liled (Month, Day, Year)		Registrar's Sign	ature	NA ACCA	~ 100-		- 0		,	MD21045	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 1. Decedent's Name (First, Middle, Last 2. Date of Death Year Month: **Physician** William Kichardson 2007 (CV)60 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Dea Examiner reneral localand If Under 1 Birthplace (State or Foreign
 Country) **Funeral** 1 M 2 □ F Maryland Director Usual Residence of Deceden 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show Department of Health and Mental Hygiene. Important; if Items 23a or 28a-f show important: if Item 27 is marked other than "natural", or Items 23a or 28a-f show important: if Item 27 is marked other than "natural be notified at you injury or other traumatic event, the Medical Examiner must be notified at once. 1 Yes 2 No Director Maryland 10g. Citizen of What Country? 10f. Zin Code och Raven Blvd. Apt. B Funeral Was Decedent Ever in U.S. Armed forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14 Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after ment of Health and Mental Hygiene. ant: If Item 27 is marked other than "natural", or Ite 1 ☐ Never Married 2 Married Specify: Blac Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify Be Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) other's Name (First, Middle, Maiden Surname) chardson 19b. Mailing Address (Street and Number or Rural Route Number Onty or Town, State, Zip Code) Saltimore, 20b. Place of Disposition (Name of cemetery, crematory or other of Disposition 1 Burial 2 □ Cremation 3 ☐ Removal from State Crownsville Vet 4 □ Donation 5 □ Other (Specify) 21. Signature of Fun ervice License 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dyin shock, or heart failure. List only one cause on each line. such as cardiac or respiratory arrest Immediate Cause (Final disease or condition resulting in death) **Physician** The to (or as a consequence of): /Medical Examiner accinoma Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner requires that the death certificate be executed the burial-transi Hyzer rens100 and Due to (or as a consequence of): P.O. Box 68760, physician as for use IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a 9□Unknown 9 Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Be Completed by 1 Yes 2 No 3 Probably 4 Unknown page 2 should been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an certificate has 1□ Yes Physician: 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🗖 No 3□ DOA Certification: To 1 Inpatient 2 ☐ ER/Outpatient this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending 1 Natural 2 Accident 5 Pending Injury Jepital or .
4 hours after dea..
ratal Director: A'
in by the 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) fo the ... within 24 hour. the Funeral Dire. 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. digistrar's Signature State

DHMH 17 Rev 1/2001

Registrar

Mardson

ORIGINAL

Physician /Medical Examine

Department of Health ar important: if item 27 is any Injury or other trau once.

Physician

/Medical

Examiner

Director

Funeral

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Completed

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Funeral

Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
ant: If Item 27 is marked other than "natural", or items 23a or 28a-f show

Baltimore, Maryland 21215-0036

Examiner law requires that the death certificate be executed Box 68760

burial-transi use as After this death. within 24 hours after death To the Funeral Director:

Division or Vital Records, P.O.

To the Hospital or Attending Physician:

Physician/Medical

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Completed

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Medical

that initiated events ' resulting in death) Last	Due to (or as a consequence of): d.								
IF FEMALE: 23b. Was decedent pregnant in the past 12 mgnths? 1 □ Yes 2 ☑ No 9 □ Unknown	23d. Date of delivery Month Day Year								
Diabetes Melli	contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Monknow							
Hypertension		24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 25c.							
25. Was case referred to medical	26. Place of Death (Check only one)								
examiner? 1 ☐ Yes 2☐ No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)								
27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigatio	(Month, Day Year) Injury Work? n M 1 ☐ Yes 2 ☐ No	f. Describe how injury occurred							
3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)	Location (Street and Number or Rural Route Number, City or Town, State)							
	nysician: To the best of my knowledge, death occurred at the time, date and place, and miner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.								

29c. License number

RESOUDI

Baltimore, Manyland 2/225

29d. Date signed (Month, Day, Year)

October 142007

State Registrar

6

29b. Signature and title of certifier

VILLNERWAND HOUSESTUFF PHYSICIAN

			1 _ State	state of Maryland		rtment of H				33037
ę	w.		Registrar 1. Decedent's Name (First, Middle, Last)		Cer	incate or i	Jealii	2. Date of Death). NO.	3. Time of Death
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*	Examin	er	4a. Facility Name (If not institution, give stre	et and number) Wising Cen	ter	4b. City, Town, o	Location of Death	ore	4c. County of De	ath
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2	Director		216-18-9354 Usual Residence of Decedent	85	Yrs.			July 8,	1922 N	Maryland
	aryland show	_	10a. State 10b. County		Town or Loc				<u> </u>	10d. Inside City Limits 1 ☐ Yes 2 🕱 No
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	th with 23a or	a D	14240 Cuba Road				030		USA	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Importent: If Item 27 ie marked other then "naturel", or Iteme 23s or 28e-f ehow any injury or other traumatic event, the Medical Examinat must be notilled at once.	by Funeral Director	11. Marital Status 12. 1 Never Married 2 Married 3 XWidowed 4 Divorced	Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give ☐ Year or Dates:	l1	/as Decedent of H Yes, specify Cuba ☐ Yes 2 X No	lispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	Black, Wi	nencan Indian, hite, etc. Vhite
Maryland 21215-0036	72 hounature	eted	15. Decedent's Educat (Specify only highest grade of	on	(Give k	ent's Usual Occup	during most of work		3b. Kind of Busines	ss/Industry
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Z	ould b	10	Lee H. Pumphrey 19a. Informant's Name/Relationship (Type.	Orine)	40h Marilla		Mary Grif		0't - T C***	7-0-4-1
	nd 2 sl alth an 27 ie r ir traur		Mark Leuba	Son			and Number or Run Search Cir			ty, MD 21042
Baltimore,	of Head		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Rem	com	e of Dispos letery, crem	ition (Name of atory or other plac	ce)		c. Location - City	
Him	it. Pag rtment: rtent: njury o		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee		raine		10/16 ss of Facility Ste 1			Maryland ab Witzke
Ba	Dep Impo		& Edwar H. Per	kins	Fu	neral Ho	ome of Cat idson Aver	onsville nue; Cato	, Inc. nsville,	MD 21228
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. 4.	/Medical Examiner		resulting in death)	Due to (or as a consequer	nce of):	ankon	a dais	0410		Mean
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	ficate be executed physician and is the burial-transit	Examiner	Cause (Diseese or injury that initiated events resulting in death) Last	Due to (or as a consequer	200 of\:					
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	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Medical (29a. Certifier (Check only one) Medical Examiner	an: To the best of my knowle On the basis of examination and manner stated.	edge, death n and/or inv	occurred at the tinestigation, in my o	ne, date and place, pinion, death occur	and due to the cau red at the time, dat	ise(s) and manner e and place, and d	as stated. ue to the cause(s)
	To the To the Court	2	29b. Signature and title of certifier	7 Mer	mo	29c. Licens	6 number	290	d. Date signed (Mo	nth, Day, Year)
	10		30. Name and address of person who comp	oleted cause of death (Item 2	3a) (Type, F	Print)	Himore	Many	land	21227
	Sta Registr		31. Date (iled (Month, Day, Year)	32: Registrar's Signatur	a Anna	Es .		/		//
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Registrar

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Registrar's Signature

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MEDILAL

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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31. Date filed (Month, Day, Year)

ORIGINAL

			1 - State Registrar Amend 29d, perMD, g872	2. 10/16/07					Reg. No.	07	33040				
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7	Examin	er	FOREST HILL HEALTH & R		CER		EST HILL			HARF	ORD				
_44	Funeral Director		5. Social Security Number 6. Sex 1 □ M 2√2 F	7. Age (In yrs. Id	Vrs	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da Apr. 8	y, Year)		place (State or Foreign htry) York				
	pu ,		Usual Residence of Decedent		, Town or Lo	cation		7101.0	1522						
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	the N 28a-	Director	Maryland Harford 10e. Street and Number	Be]	LAir	10f. Zip Code			10g. Citizen of \	What Cour	ntry?				
	h with		1002 Chantery Drive			21015			USA						
	ems ser mu	Funeral	11 Marital Status 12. Was D	ecedent Ever in U.S Forces?	S. 13.1		Hispanic Origin? (S an, Mexican, Puer	pecify Yes or No		e - Americ					
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2121	within ene. Ithan "	Completed	Elementary/Secondary (0-12) Colleg	e (1-4or 5+)			during most of word)	9	7moria:	n Bo	d Cross				
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Maryland	ages 1 and 2 should be filed int of Health and Mental Hygi : If Item 27 Is marked other or other traumatic event, t	-	19a. Informant's Name/Relationship (Type. Print)		19b. Mailir	ng Address (Street	and Number or Ri	ural Route Numb	er, City or Town,	State, Zip	Code)				
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ore	Pages 1 nent of Hu int: if iter iny or oth		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal fro	om State	emetery, crei	sition (Name of matory or other pla	· · · · · · · · · · · · · · · · · · ·	Date	20c. Location -	•	•				
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Ba	permit. Pag Department Important: i any injury o		21. Signature of Funeral Service Licensee	ely			ess of Facility Ineral Ho Shury Roa			rvla	nd 21009				
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S S	tendile eath. tor: A the fu	catic	2 Accident investigation			M 1]Yes 2□No								
DIVISION OF	al or At s after d il Direct d in by	Certification:	4 Homicide determined 28e. Pla	ace of injury - At hor uilding, etc. (Specify	me, farm, str	eet, factory, office		28f. Location (City or To	Street and Numb vn, State)	er or Rura	d Route Number,				
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	edical C	29a. Certifier (Check only one) Certifying Physician: To Certifying Physician: To Check only one)	the best of my know e basis of examinat nanner stated.	wledge, deat tion and/or in	h occurred at the ti vestigation, in my	ime, date and place opinion, death occ	e, and due to the urred at the time,	cause(s) and ma date and place,	anner as s and due to	tated. the cause(s)				
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	-		10000			0 3	2299		ctober 8,	2007	2003				
(271		30. Name and address of person who completed c	ause of death (Item	23a) (Type,		- , ,								
7)			MACPHAIL		- BEL A	AIR, MD.	21014							
	Sta	te	31. Date filed (Month, Day, Year) 32	2. Registrar's Signat	ture	oseles									

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** September 27, 2007 5:49 AM M Jessie Lambden Stewart /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince George's Laurel Regional Hospital Laurel If Under 1 Year | If Under 24 Hrs. | B. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1□M 2♥F Yrs. May 23, 212-20-2300 Director Maryland 87 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ir than "naturel", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1600 Rainbow Drive 20905 USA Peges 1 and 2 should be filed within 72 hours after deeth nent of Health and Mental Hygiene. Int: If item 27 is marked other than "naturel", or Items 23. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 white 1 ☐ Yes 2X No Specify: δ 3 ☐ Widowed 4 ☑ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16h. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) 12 accountant government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Edward J. Lambden Ida Smullen ٩ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1600 Rainbow Drive Silver Spring, MD other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Department of Important: If eny injury or once. 4 ☑ Donation 5 ☐ Other (Specify) 21. Sign num of Euneral 9 ryice Licens, e CODA I Q S • Wa Director State Anatomy Board 655 W. Baltimore Street 21201 my Baltimore, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pul mon ary **Physician** 5mb. lis HAR5 disease or condition resulting in death) /Medical After Large ... F. Michigal Schuller Due to (or as a consequence of): Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of). Examiner attending physicien and for use as the burial-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day 4 Pregnant at time of death 5 Other (specify) P.O. I certificete has been signed by the a rector, page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ۾ 1 Yes 2 No 3 Probably 4 Nhknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? Division of Vital 1 Yes 2 □ Hospital or Attending Physicien: After this certification, funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 2 ER/Outpatient 3 DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Injury 1 Natural 5 Pending 11:00 P efter death. 9-21-2007 28f. Location (Street and Number or Rural Route Number,
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28f. Location (Str 1 ☐ Yes 2 No 2. Accident investigation the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide encastle Road within 24 hours el To the Funarai C completely filled i Home Territying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) th st 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 2 Sep 27. 2007 am D 28998 PRITAM 5'SAINI 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Lone 9101 Cherry Suite 2/1

State Registrar 31. Date filed (Month Day, Year)

Carried

32. Registrar's Signature

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Physician Medical Examiner Physician Medical Examiner Physician Medic	į,			23a. Part1. Enter the disease, or complication shock, or heart failure. List only one care	ons that caused the death. Do not ause on each line.	enter the mode of dying	, such as cardiac or r	espiratory arrest,		Approximate Interval Between
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A degree of the property of th	<u></u>	The icate l						performed' 1□ Yes 2	death? √o 1 ☐ Yes	2 □ No
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30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jessa Edelman MD 5401 old Court Rd Randallstown MD State 31. Date filed (Month, Day, Year) 32 Hegistrar's Signature	0	g Phy er this eral d		27. Manner of Death 2	8a. Date of Injury 28b. Time					city)
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30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jessa Edelman MD 5401 old Court Rd Randallstown MD State Registrar 31. Date filed (Month, Day, Year) OCT 1 6 2007 32 Registrar's Signature 2413.		То th within To th сотр	Me	29b. Signature and title of certifier		l l				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jessa Edelman MD 5401 old Court Rd Randallstown MD State Registrar 31. Date filed (Month, Day, Year) OCT 1 6 2007 32. Registrar's Signature 2.113.		4		1	MO	DOG	66171	00	tober	11,2007
State Registrar OCT 1 6 2007 December 16 2007 State Registrar Signature 2113.	(4 6	. 1	e, Print)				
Registrar OCT 1 6 2007 Augus & Septe		Sto.	to.			54010	ld Cour	t rd k	andall.	Stown MUD
					Brews B. A.	carlo				arrs;

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 25 State of Maryland / Department of Health and Mental Hygiene per me, g8/2, 10/11/0/dhb Gentificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2007 August 20, **Physician** 9:30P MARJORIE ELLEN TILMAN /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner None Future Care Lochhearn Baltimore 8. Date of Birth (Month, Day, Year) May 21, 1954 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 6 Sev 7. Age (In yrs. last birthday) **Funeral** Days Min 1 □ M Yrs Mary 1 and 53 217-62-6581 **Director** Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If Item 27 Is marked other than "natural" --- any injury or other traumatic event. 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1XXYes 2 □ No Director Maryland | None Baltimore 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 21215 USA 4800 Seton Drive by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White etc. XXNever Married 2 ☐ Married 1 □ Yes XX No White Specify. Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Disabled None 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William R Tilman Sr Olga Hazbrook 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Sister 39 Guinevere Court Baltimore, Maryland 21237 Teresa Hirsch 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 🛣 X remation 3 □Removal from State Green Mount Crematory 8/23/07 Baltimore, Maryland □Donation 5 □ Other (Specify) 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home Inc nature of Fu 6500 York Road Baltimore, Maryland 21212 23a. Part1. Enter the disease, or compleshock, or heart failure. List only of Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical as a consequence of Examiner Sequentially list conditions, if arry, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine MEDICAL EXAMINER or Attending Physician: The law requires that the death certificate be executed CERTIFICATION APPROVED Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 21 ☐ No Month Day Vear 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division or Vital Records, 1 ☐ Yes 2 No 3 Probably 4 Donknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: Certification: To 1 XYes 1 Inpatient 2 ☐ ER/Outpatient 3□ DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No after death 2 Accident 3 ☐ Suicide 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 Homicide within 24 hours a To the Funeral I filled 🗄 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. ature and title of certifier 29d. Date signed (Month, Day, Year) ed cause of death (Item 23a) (Type, Print)

Registrar

State

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32. Registrar Signatur

Yassin

			1- For State of Maryland / Department Certificate Certificate	of Health and Mental I	Hygiene Reg. No.2007	33044
	Physici /Medic	al	1. Decedent's Name (First, Middle, Last) THOMAS HUBERT TURNER 4a. Facility Name (If not institution, give street and number) 4b. City, 1	2. Date o Month OCTO	Day Year	3. Time of Death 5:40 A
	Examin Funeral Director		609 Red Oak Avenue Edo	Tewood Tyear If Under 24 Hrs. 8. Date of Min. Feb.	Harford (Birth Day, Year) 9. Birth	
	Maryland -f ehow		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	th with the 23s or 28s	Funeral Director	Maryland Harford Edgewood 10e. Street and Number 10f. Zip. 609 Red Oak Avenue 210		10g. Citizen of What C	ountry?
9036	within 72 hours after death with the Maryland ene. Then "paturel", or Iteme 23e or 28e-f ehow the Modical Exemitive trivial be incliffed at	ρ	Armed Forces? If Yes, speci 1 □ Never Married 2 ☑ Married 1 ☑ Yes 2 □ No If Yes, Give 1 □ Yes 2 Year or Dates:	ent of Hispanic Origin? (Specify Yes o ify Cuban, Mexican, Puerto Rican, etc. No Specify:	.) Black, Whi	
21215-0036	od within 72 ho giene. er then "natu , the Musical	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 3 Heavy Equip	k done during most of working	16b. Kind of Business	
Maryland	should be file nd Mental Hy marked oth imatic event	To Be (William Henry Turner	18. Mother's Name (First, Mic Kathleen Viv (Street and Number or Rural Route No.	vian Hembree	Zip Code)
	permit. Pages 1 end 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 ie marked other then "naturel", or Iteme 23a or 28a-f ehow any injury or other traumatic event, the Mudical Examiner traust be inclined at 00ce.		Laura Kathleen Turner / Wife 609 Red Ca 20a. Method of Disposition 12 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Nam cemetery, crematory or other)	k Ave., Ed ewood,	MD 21014 20c. Location - City or	r Town, State
Baltimore,	permit. Pa Department Important any injury once.		21. Signatur or Fulleral Service Licensee 22. Name and MCCOMM	scopal 10-17-07 Addass of Facility S Funeral Home, P Cokesbury Road, Ab		_
	Physician /Medical		23a. Part Fenter the disease, of complications the caused the death. Do not enter the mode shock, or heart failure. List only one cause of each line. Immediate Cause (Final disease or condition resulting in death) a.	of dying, such as cardiation respirato	ory arrest,	Approximate Interval Between Onset and Death
68760,	ite be executed xx is in the burial-transit and in the burial-transit and its interest and its int	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	/		/
.O. Box	The law requires that the death certifica site has been signed by the attending ph page 2 should be detached for use as it	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pre 4 □ Pregnant at time of death 5 □ Other (spe		23d. Date of de Month	blivery Day Year
S, D	w requires that been signed b should be dete				Did tobacco use contribute t	o the cause of death?
Vital Record	ysician: The law is certificate has b director, page 2 st	e Completed	25. Was case referred to medical	a	es 2 XNo 1 Yes	
ō	2 € 2	To B	examiner? 1 Yes 2 LNo Hospital: 1 Inpatient 2 ER/Outpatient 3 DO.	A Other: 4 □ Nursing Home 5 ☑ F	Residence 6 □Other (Speribe how injury occurred	ecify)
Division	or Attending Phy ifter death. Director: After thi in by the funeral of	Certification:	1 Natural 5 Pending (Month, Day Year) Injury 2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, building, etc. (Specify)	Work? 1 ☐ Yes 2 ☐ No office 28f. Locati	on (Street and Number or R r Town, State)	Rural Route Number.
	To the Hospital or Attentwithin 24 hours after deatl To the Funeral Director: completely filled in by the	edical	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred a company of the pass of examination and/or investigation, and manner stated.	It the time, date and place, and due to in my opinion, death occurred at the ti	the cause(s) and manner a ime, date and place, and du	s stated. e to the cause(s)
)	To the within 2. To the complet	Σ	29b. Signature and hitlerof serials 29c. 39. Name and address of person who completed cause of death (Item 23a) (Type, Print)	License number H39027	295 Bate signed (Mon	nth, Day, Year) n 15 2007
5	Sta Registr		31. Date filed (Month, Day, Year) 32. Registrar's Signature	enkelley to	Semed MD	21040
			UCT TO COOL SOME			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 14 2007 0. OCTOBER Duane Terry 4b. Cify, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) ANNE undfl KIMORE WASHINGTON MEDICAL 3. Date of Birth (Month, Pay, Year, 11/2/1926 Social Security Number Age (In vrs. last birthday Months Days 1 M 2 □ F 80 474-20-8684 MN Usual Residence of Decedent 10d. Inside Cify Limits 10c. City, Town or Location 10a. State 1 ☐ Yes 2 ☑ No MD Anne Arundel Glen Burnie 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21061 USA 903 Phylen Court 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☑ No Specify. Specify. White 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Metals Metallurgist 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Hallycon A. Oppelt James L Terry 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 903 Phylen Crt., Glen Burnie MD 21061 Mrs Letha G Terry / wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 10/17/2007 Crownsville MD MD Veterans Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Puneral Service Licensee 2. Name and Address of Facility
Singleton Funeral & Cremation
2nd Ave SW Glen Burnie MD 21061
Sr Srvc Approximate Interval Between Onset and Death ed the death. To not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Date of delivery Month Day Year contribute to the cause of death? 3 Probably 24b. Were autopsy findings avallable prior to completion of cause of death?
1 ☐ Yes 2 ☐ No

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

r 28a-f show notified at

r than "natural", or items 23a or the Medical Examiner must be r

Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' any injury or other traumatic event, the Me

Pages 1 and 2 should be

Director

Funeral

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Completed

Be

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

death certificate be executed

Division or Vital Records, P.O. Box 68760,

and attending physician for use as the buria has certificate

After t To the Hospital or Attendi within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

Examine Physician/Medical ģ Completed Be Certification: To

Cause (Disease or injury that initiated events resulting in death) Last	C	
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 9 □ Unknown	23d. Date of delivery Month Day Year
Part II. Other significant conditions	contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death
		24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No
25. Was case referred to medical	26. Place of	Death Check onl one
examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursin	ng Home 5 ☐ Residence 6 ☐ Other (Specify)
27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 28c. Injury at Work? 1 Yes 2 No	28d. Describe how injury occurred
3 ☐ Suicide 6 ☐ Could not b determined		28f. Location (Street and Number or Rural Route Number City or Town, State)

29a. Certifier

MD

29c. License number 045149

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

address of person who plated cause of death (Item 23a) (Type, Print Glen Burnie MD 20161 brite D takal

🖊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

State Registrar

Medical

32. Registrar's Signature 31. Date filed (Month, Day, Year) 6

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) ^{Day}4 October 11:10p M 2007 Urban Albert George 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Baltimore Towson Gilchrist If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day Sept. 1947) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Months Country) Maryland 1⊠M 2□F 1923 217-16-6857 84 Usual Residence of Decedent 10c. City, Town or Location 10d, Inside City Limits 10b. County 1 ☐ Yes 2 No Towson Md. Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 21286 205 E. Joppa Rd. 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2X Married Specify: White 1 ☐ Yes 2 🔀 No Specify. 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) Self Employed Painter 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Anna Watson Vincent Urban 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 205 E. Joppa Rd. Towson, Md. 21286 Mrs. Charlotte Urban∕ Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 10-18-07 Baltimore, Md. Parkwood Cemetery 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Ruck Towson Funeral Home, 1050 York Rd. Towson, Md. 23a. Part1. Enter the disease, complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Lift only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Dementia y cars Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 | Yes 2 No 3 | Probably 4 | Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed' 1□ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Mother (Specify) No 5 PICE 1 ☐ Yes 2 M2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 🗷 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide

Examiner o Vital or Attending Physician; ō 24 hours after death Funeral Director: Hospital within 24

Examine Physician/Medical ģ Completed Be Certification: To Medical

Physician

/Medical

Examiner

Funeral

Director

"natural", or Items 23a or 28a-f show edical Examiner must be notified at

Director

Funeral

<u>م</u>

Completed

Be

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death with the Maryland

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natu any Injury or other traumatic event, the Medical any Injury or other traumatic

Physician

/Medical

101-State

Registrar DHMH 17 Rev 1/2001 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

AMON J. WANUS M 6701 N. Charles St TONSON ND 2120 +

31. Date filed (Month, Day, Year)

4 | Homicide

(Check only one)

29b. Signature and title of certifier

29a. Certifier

32. Registrar's Signature

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Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D 58303

29d. Date signed (Month, Day, Year)

15 2007

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieney Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Van Gorden 10 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Parkisille Genesis Bartone Cronwell 5. Social Security Number Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1□M 2□¥ Hours 164-24-3136 Director 82 Nov.25,1924 England Usual Residence of Decedent Dermit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examination. 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits MD Baltimore Middle River Director 1 ☐ Yes 2 ☑ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21220 354 Earls Road by Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Yes 2X No Specify: Specify: White 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker own home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Lily E. Beatty unknown ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 600 Washington Ave. Towson MD Lawrence Schmidt 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 remation 3 ☐ Removal from State Bayview Crematory /6/11/67 Baltimore MD 4 Donation Other (Su cify) 22. Name and Address of Facility 300 Mace Ave. Balto. MD Connelly Funeral Home of Essex 21221 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** days /Medical Due to (or as a consequence of) **Examiner** Due o (or as a o nsequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last 7 PO.23 Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed?

1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 M Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA 1 Yes 2 No 2 nours after death.

neral Director: After the filled in by the funeral 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b, Time of Certification: 28d. Describe how injury occurred 5 Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a 29a. Certifier 1 Ccertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year)

OCT 1 6 2007 10701 H Charles St Soite 4202 Town mel 21204 State Registrar

			For State Ragistrar	State of Marylane		rtment of He			ene 0	07	33048
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	Examin		4a. Facility Name (If not institution, give			4b. City, Town, or			4c. County		
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	Funeral Director		5. Social Security Number 6. Sec. 215-09-9889	9x 7. Age (<i>In yr</i> s. <i>I</i> □ M 2 Y F 9(Months Days	Hours Min.	8. Date of Birth (Month, Day, Feb 2, 1	Year) 917	Goun Mars	lace (State or Foreign try) / Land
ч			Usual Residence of Decedent					11029 1		TIGL	rand
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Ž	2 2 2 2 2		Ann L. von Lossber	g, Daughter	9676	Swynn Parl	k Drive	Ellicott	City,	MD 23	1042
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Ĕ	Pages ment of ant: It its ury or o		4 Donation 5 Other (Specify	Lori	raine I	Park	10/1.	5/07 V	Voodla	vn Mai	cyland
Baltimore, Maryland 21215-0036	permit. Pag Department Important: I eny Injury o		21. Signature of Funeral Service Licen Thomas Gregor	S00	22	Name and Address MacNabb Fi 301 Fredet	s of Facility Uneral Ho rick Road	ome, P.A. d Catonsy	ville.	Marv1	land 21228
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	6		30. Name and address of person who	completed cause of death (Item	23a) (Type,	Print)	1 '	1	0,	,	1 2007 ~ MD 21228
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State of Maryland / Department of Health and Mental Hygien 2 1 1 7

33049 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 945 A 10-13-2007 Delma Dee Wilson /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Harford Edgewood 1805 Sandee Court If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 03-24-1956 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months 1 □ M 2 🕅 F Maryland 51 Director 218-74-0423 Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b County 23a or 28e-f ahow the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Edgewood Maryland Harford Direct 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 21040 1805 Sandee Court death Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? or itema 11. Marital Status 1 Yes 2 No
If Yes, Give
Year or Dates: filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced "natural", Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Itam 27 is marked oth any lighty or other traumatic avent 9DRS: Be Dolores Martin ဥ Donald Gudenius 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1805 Sandee Court Edgewood, MD 21040 (Mother) Dolores Willey_ 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 10/2007 Baltimore, Maryland Bayview Crematory 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Schimunek Funeral Home of Bel Air 21. Signature of Funeral Service picensee 610 W. MacPhail Rd Bel Air, MD 21014 Morro 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) COPD 10 year **Physician** /Medical Due to (or as a consequence of): Examiner 10 years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Dua to for as a sunsequence of Examiner o the Hospitel or Attending Physician: The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical use as the igned by the attending be detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 23a. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1 Yes 2 X-No 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No ٩ After thi 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 27. Manner of Death Certification: 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No death. investigation i Director: d in by the within 24 hours after dea To the Funeral Director 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 4 T Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 00058878 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Belcamp MD 2101 1321 Riverside Parlluay Suite 32. Pagistrar's Signature 31. Date filed (Month, Day, Year) State

Registrar DHMH 17 Rev 1/2001



Division of Vital Records, P.O. Box 68760,

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year) OCT 1

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32. Registrar's Signature

			For State Registrar		State o	of Maryla		artment of rtificate of			lental H	lygien Reg. N	211111	33051
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Baltimore,	permit. Pages 1 an Department of Heal Important: If item 2 any Injury or other once.		21. Signature of Fu	uneral Service Lie	censee	0.10	~	2. Name and Add		I _A I ^C			AL HOME-	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** October 11, 2007 Francis C. Wolle 8:15A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Greater Baltimore Medical Center Towson Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9-7-1917 6. Sex Birthplace (State or Foreign Country) **Funeral** Days Hours Min 218-07-5199 XXM 2□ F 90 Director Maryland Usual Residence of Decedent 10a, State 10c. City, Town or Location 10b. County 10d. Inside City Limits notified 1XX es 2 No Director N/A Maryland Baltimore or 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be 4625 Keswick Road 21210 or items 23a USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes XXNo If Yes, Give 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Married 2 ☐ Married þ 1 ☐ Yes 🏋 No Specify. Specify: 3€XWidowed 4 □ Divorced white Year or Dates: Completed other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) other than Elementary/Secondary (0-12) College (1-4or 5+) Pages 1 and 2 should be filed withi ment of Health and Mental Hygiene. ant: if item 27 is marked other thar Supervision - Coin box C&P Telephone 11 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Frank Wolle Eleanor Yockel ျှ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara Retz Daughter 2115 NE 3rd Way Boca Raton 33431 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages Department of Important: If it any injury or o Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Moreland Memorial Park 10/15 Parkville, Maryland 21. Signature of Pureral Service Linnee 22. Name and Address of Facility Burgee-Henss-Seitz Funeral Home, Inc. 3631 Falls Road Baltimore, Maryland Parti- for the disease or comblications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or neart failure. Ust only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician resulting in death) /Medical Due to (or as a Examiner Esquentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine The law requires that the death certificate be executed as the burial-trai resulting in death) Last Due to (or as a consequence of) attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not estulting in the underlying cause given in Part I. 23e. Did tobaccoruse contribute to the cause of death? 1 robably 4 Unknown Completed 24a. Was an 24b: Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No s certificate has b lirector, page 2 s 2 No 1∐ Yes 25. Was case referred to finedical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 20 No ို 1 Inpatient 2 ER/Outpatient 3 DOA funeral 27. Man of Death 28b, Time of 28a. Date of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural (Month, Day Year) 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

Division or Vital Records, P.O. Box 68760,

altimore,

To the Hospital or Attendia within 24 hours after death. To the Funeral Director: A filled in by the

State Registrar

Medical

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Charles St

1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certiffer

29a. Certifier

State of Maryland / Department of Health and Mental Hygiene 2007 33053 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Month **Physician** THEODORE ROOSEVELT WEDDINGTON SR. October 2007 2:40 a /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 6518 HILLTOP AVENUE BALTIMORE If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 X M 2 □ F Yrs. 82 Director 224-42-4475 AUG. 20 1925 VIRGINIA Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f show at 1XXYes 2 ☐ No Director MARYLAND N/A BALTIMORE 10g. Citizen of What Country? 10e, Street and Number 10f. Zip Code 23a or with 8 6518 HILLTOP **AVENUE** death v r than "natural", or items 23s the Medical Examiner must 21206 U.S.A Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status filed within 72 hours after 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2KKNo Specify: Specify: BLACK þ 3

Widowed 4

Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) BALTO CITY PUBLIC WORKE 7th grade PIPE LAYER permit. Pages 1 and 2 should be filed to Department of Health and Mental Hygic Important: If item 27 is marked other any injury or other traumatic event, the 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be HARRY WEDDINGTON IRENE WEDDINGTON ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Theodore R. Weddington Jr./Son 6518 Hilltop Ave., Baltimore, Maryland 21206 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State ₩ Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) DRUID RIDGE 10-16-07 BALTIMORE, MARYLAND 21 Sonature of Funeral Service Licen 22. Name and Address of Facility Merica Clown WILLIAM C BROWN COMMUNITY FUNERAL HOME P.A. 1206 W NORTH AVENUE 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** LUNG CANCER /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (ulsease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner that the death certificate be executed burial-transit and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 physiclan Physician/Medical the IF FEMALE: nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for 1 in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 OBSTRUCTIVE PULMONARY 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate 1 ☐ Yes 2 ☑ No 1∐ Yes 2 2No i or Attending Physician: after death. Director: After this certifica 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours at To the Funeral Completely filled in Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29c. License number 29d. Date signed (Month. Dav. Year) 29b. Signature and title of certified

State Registrar THOMAS

31. Date filed (Month, Day, Year)

OCT 1 6 2007

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Baltimore,

Mary 1

724 MAIDEN CHOICE LANE SUITE 204

MO 21228

BATIMORE

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygien 907Certificate of Death 2. Date of Death 3 Time of Death 1. Decedent's Name (First, Middle, Last) October 2007 12:40 pm **Physician** Ward Elizabeth /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Cockeysville Broadmead Months Days Hours Min. Feb. 19, Year 910 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Mary Tand 215-10-9975 1 □ M 2X口 F 97 Director Usual Residence of Decedent 10d. Inside City Limits the Marylend 10c. City, Town or Location 10a, State 10b. County 7 is marked other than "netural", or items 23a or 28a-f show treumatic avent, It e Modical Examiner must be multiled at 1 Yes 2 No Cockeysville Baltimore Director Md. 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21030 USA 13801 York Rd. Pages 1 and 2 should be filed within 72 hours after deeth inent of Health and Mental Hyglene. ant: If item 27 is marked other than "netural", or items 23 Funeral 14 Bace - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 1 No Specify: Specify: White þ 3 X Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Davenport Peddicord Lucie Everett 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1124 Concordia Drive Towson, Md. 21286 Mr. George Ward, Jr./ Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages Department of Important: If it any injury or o 1 Burial 2 Cremation 3 Removal from State Timonium, Md. `4 □Donation 5XIOther (Specify)Entombment Dulaney Valley Mem. 10-18-07 22. Name and Address of Equilibration Home, 1050 York Rd. Towson, Md. 21. Signature of Funeral Service Licenses 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) dar Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examiner Physicien: The law requires that the death certificate be executed that initiated events resulting in death) Last attending physician and Due to (or as a consequence of): Box 68760, Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☑ No 4☐Pregnant at time of death 9☐ Unknown 5 Other (specify) ed by the a detached f P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Division of Vital Records, 20 No 3 Probably 4 Unknown 1 Tes Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an After this certificate has 1 ☐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ٩ 1 Tes 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 27. Manner of ath Certification: ospitel or Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident **Director:** 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide determined filled in by 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai 29a. Certifier complete ly within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of coatifier 0 who completed cause of death (Item 23a) (Type, Print) MOHMA Year) 32 Registrar's Signature State Registrar

10-12-0

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 9:54 p Darcel Womack October 8. 2007 /Medical 4a. Facility Name (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Holy Cross Hospital Silver Spring

If Under 1 Year | If Under 24 Hrs. Montgomery 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday, 5. Social Security Number 6. Sex **Funeral** Days Hours Months 1 M 2 X F 114-38-2056 59 January 14, 1948 New York Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County ral", or items 23a or 28a-f show Examiner must be notified at 1 □ Yes 2VX No Director Maryland Prince Georges Lanham 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number 7023 Cipriano Woods Court 20706 USA Funeral 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 □ Never Married 2 □ Married 1 ☐ Yes 2 ☑ No Maryland 21215-0036 'natural', or Specify: Black Specify þ 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry the Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Frame Attendant Verizon 12 permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: If item 27 is marked other any Injury or other traumatic event, is 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John Henry Mitchell Sarah Rembert 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Aaron Womack- son 7023 Cipriano Woods Court, Lanham, Maryland 20706 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State Metro Crematory 10-11-2007 Catonsville, Maryland 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Fleck Funeral Home, 21. Signature of Funer vice Licensee INC. 7601 Sandy Spring Road, Laurel, Maryland 20707 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Cardiomyorathy resulting in death) /Medical Due to (or as a consequence of): Examiner Years Obesity Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical the as nse 23c. If yes, outcome pf pregnancy 1 □Live birth 2 □ Fetal death 4 □ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day Year for in the past 12 months? 5 Other (specify) ☐Yes 2 No 9 Unknown 9∏Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Sepsis Completed Acidosis 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☑ No 24a. Was an page 2 s has autopsy pertormed certificate 1 Yes 2 | No the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death Check onl one director Be Other: Hospital: 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 🖺 Yes 2**X**No 1 🗓 Inpatient Certification: To 28b. Time of 28a. Date of Injury 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death (Month, Day Year) Injury 1 Natural 5 Pending investigation М 1 ☐ Yes 2 ☐ No ithin 24 hours after death.

o the Funeral Director: A

ompletely filled in by the fu 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifies within 7 29b. Signature and the of certifi 29c. License number 29d. Date signed (Month, Day, Year) 2 D0061887 October 9, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1500 Forest Glen Road, Silver Spring, Maryland 20910 Dr. Ira Rabin 32. Resistrar's Signature 31. Date filed (Month, Day, Year) State Registrar 2007

DHMH 17 Rev 1/2001

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Kevin	Ware

evin Ware	State of Maryland / Department 1-For State Certificate		2007 3303			
Physician edical Examine	1. Decedent's Name (First, Middle, Last)	2. Date Monti	of Death 3. Time of Death Day Year 2055 hrs			
	4a. Facility Name (if not institution, give street and number) 1100 West Baltimore Street	4b. City, Town, or Location of Death Baltimore	Reg. No. of Death th Day Doer 11, 2007 4c. County of Death 2055 hrs te of Birth (MM/DD/YYYY) 4c. County of Death May Lee of Birth (MM/DD/YYYYY) 4c. County of Death May Lee of Birth (MM/DD/YYYYY) 4c. County of Death May Lee of Birth (MM/DD/YYYYY) 4d. County of Death May Lee of Birth (MM/DD/YYYYY) 4d. County of Death May Lee of Country) 10d. Inside City Limits 1 Ves 2 No 10d. Inside City Limits 1 Ves 2 No 11d. Race - American Indian, Black, White, etc. Specify: Black 16b. Kind of Business/Industry Reflections Cuts Middle, Maiden Surname) 12d. Location - City or Town, State 12d. Date of delivery Month Day 12d. Date of death? 1 Ves 2 No 1 Ves 2 N			
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	Yrs. If Under 1 Year If Under 24Hrs. 8. Date Months Days Hours Min.	Foreign			
ow any	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Lo	baltimore				
th the Maryland 23a or 28a-f show notified at once.	10e. Street and Number 833 Abboth Ct.	10f. Zip Code 21212	10g. Citizen of What Country?			
hours after death with the Maryland inaturals, or items 23a or 28a-f she Examiner must be notified at once and by Emperal Director	11. Marital Status 1 Never Married 2 Married 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 3 Wildowed 4 Divorced If Yes Give Year	Was Decedent of Hispanic Origin? (Specify Ye If Yes, specify Cuban, Mexican, Puerto Rican, e Yes 2 No specify:	tc.) White, etc.			
2 = 6		dent's Usual Occupation (Give kind of work don- g most of working life. DO NOT use retired) Barber				
21215-0036 uld be filed within 7 Mental Hygiene. marked other than e event, the Medica	Hardy Ware	18.Mother's Name (First, Melva Bu)	dev			
MD nd 2 sho alth and m 27 is aumati	Amber Ware-daughter 53					
More Pages 1 sent of H ant: If it	1 Burial 2 Cremation 3 Removal from State crematory of Lorray	r other place) Le Park Cem. 10/18/	07 Woodlawn Maryland			
Balti Permit. Departu Importa	23a. Part I. Enter the disease, or complications that caused the death. Do not ent		tory arrest, shock, or heart Approximate Interval			
/Medical xaminer	failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Multiple Gunshot Wounds Due to (or as a consequence of):					
ed	Sequentially list conditions, if any, leading to immediate ease. Enter Underlying Cource (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):					
	d. UNPENDED AMENDED					
Sox 6876(leath certificate e attending physical for use as the b		Fetal death 3 Ectopic pregnancy Other (Specify)				
ires that the disagreed by the detached	3	and distantlying deaded given in a service				
of Vital Records, ng Physician: The law requir ther this certificate has been a meral director, page 2 should b			autopsy prior to completion of cause of death?			
f Vital Rec Physician: The pr this certificate ral director, page	25. Was case referred to medical examiner?	26.Place of Death (Check only one tient 3 DOA Other; Nursing Home				
on of cending Planth. or: After the funeral		leubio				
Division o To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	2 Accident Investigation 3 Suicide 6 Could not be determined (Specify) Barber Shop					
To the Hos within 24 hd To the Fun completely		tigation, in my opinion, death occurred at the tin	ne, date and place, and due to the cause(s)			
	29b. Signature and title of certifier	29c. License number O.C.M.E.	29d. Date signed (Month, Day, Year) October 12, 2007			
2	30. Name and address of person who completed cause of death (Item 23a) Ana Rubio MD. Assistant Medical Examiner 111 Pen	nn Street, Baltimore, MD 21201				
Stat	e 31. Date filed (Month, Day, Year) 32. Regular's Signature	P				

			1- State Registrar Amend #31, perDVR, g872, 10/16/07 TT C	partment of Health and N ertificate of Death	Reg	ene 1. No. 2007 33057
	Physic /Medi		1. Decedent's Name (First, Middle, Last) Elizabeth Lorena Whalen		2. Date of Death Month 10/14/20	Day Year 3. Time of Death a M
	Exami		4a. Facility Name (If not institution, give street and number) Mandrin House 5. Social Security Number 6. Sex 7. Age (In yrs. last birthda		8. Date of Birth	4c. County of Death Anne Arundel 9. Birthplace (State or Foreign
	Director	100	577-52-3599 1□ M 2□ F 68 Yrs. Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or		02/24/193	Washington D.C.
	the Maryla 28a-f sho notified at	rector	MD Anne Arundel Curtis Ba		100	10d. Inside City Limits 1 □ Yes 2 XNo J. Citizen of What Country?
	iges 1 and 2 should be filed within 72 hours after death with the Maryland nt of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	Funeral Director	1113 Double Chestnut Ct.	21226 3. Was Decedent of Hispanic Origin? (Sp if Yes, specify Cuban, Mexican, Puerto	τ	JSA 14. Race - American Indian, Black, White, etc.
5-0036	2 hours afte atural", or it cal Examin	þ	1 Never Married 2 Married 1 Yes XX No If Yes, Give Year or Dates:	1 ☐ Yes 2 ☒ No Specify:	16	Specify: White
2121	filed within 72 Hygiene. ther than "ne	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) 12 (Gillife College (1-4or 5+) Busi	ve kind of work done during most of work DO NOT use retired) ness Owner	Se	ervice
Maryland	should be fil ind Mental H is marked oth umatic even	To Be	17. Father's Name (<i>First, Middle, Last</i>) Robert Fritz 19a. Informant's Name/Relationship (<i>Type, Print</i>) 19b. Ma	18. Mother's Nam Lorena G illing Address (Street and Number or Rur		·
	s 1 and 2 sho f Health and fem 27 is ma other traums		Debra Sussman / Daughter 4226	Landgreen St., Ro	ckville,	
Baltimore	permit. Pages 1 an Department of Heal Important: If item 2 any Injury or other once.		4□Donation 5□Other (Specify) Metro Cr	rematory or other place) Cematory 10/15 22. Name and Address of Facility The place of the pla	5/2007 Ca	atonsville, MD
8			23 × Part1. Inter the diseas, or complication hat caused the death. Do not e shork, or heart failure. Lit shifty on ause on each line.	22. Name and Address of Facility Fary L. Kaufman Fun 7250 Washington Blv enter the mode of dying, such as cardiac	d., Elkri	dge, MD 21075 Approximate Interval Between Onset and Death
8760,	Physician /Medical Examiner per partial transit whe purial-transit per private provided the private pr	cal Examiner	disease or condition resulting in death) Sequentially list conditions, if y y additions, if y y y additions, if y y y y y y y y y y y y y y y y y y	carcinoma		1 year 4 mos
P.O. Box 68	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Medical		B ⊟Ectopic pregnancy 5 □ Other <i>(specify)</i>		23d. Date of delivery Month Day Year
	w requires that been signed b should be deta	ò	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobac	cco use contribute to the cause of death?
al Records,		Completed			24a. Was an autopsy performe 1 Yes 2 1	24b. Were autopsy findings available prior to completion of cause of death? No 1 □ Yes 2 □ No
n or Vital	the Hospital or Attending Physician: The 24 hours after death, the Funeral Director: After this certificate relety filled in by the funeral director, page	on: To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No 1 ☐ Inpatient 2 ☐ ER/Outpati 27. Manner of Death 1 ☒ Natural 5 ☐ Pending (Month, Day Year) 28b. Time (Month, Day Year)	ent 3 DOA Other: 4 Nursing Ho of 28c. Injury at	h (Check only one) ome 5 Residence 28d. Describe how	ce 6 Dother (Specify) Hospice
Division	al or Attend s after death, il Director: A d in by the f	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of injury - At home, farm, s building, etc. (Specify)	M 1 ☐ Yes 2 ☐ No street, factory, office	28f. Location (Stree City or Town, S	et and Number or Rural Route Number, State)
	To the Hospital c within 24 hours af To the Funeral D completely filled in	edical	29a. Certifier (Check only one) 1 ★ Certifying Physician: To the best of my knowledge, deal of the best of my knowledge, deal call examiner: On the basis of examination and/or and manner stated.	investigation, in my opinion, death occur	and due to the caus red at the time, date	se(s) and manner as stated. e and place, and due to the cause(s)
	To To con	Σ	29b. Signature and title of certifier adjusted, up	29c. License number DXXQ2925	29d.	Date signed (Month, Day, Year) 40 ber 15, 2007
	6 Y		30. Name and address of person who completed cause of death (Item 23a) (Type 12.15 Auxgool 5 Rd. # 10.7 Ode)	nton, MD 3	4113	
	Sta Registr		31. Date filed (Month; Day, Year)- 32. Registrar's Signature	(ach)		

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** September 28, Harold Dwite Armentrout 2007 7:40 A /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Shady Grove Adventist Hospital Rockville Montgomery If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 9. Birthplace (State or Foreign Country) West Virginia 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days 1**⅓**M 2□F West 234-38-8606 82 Dec. 8, 1924 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hyglene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 X No Director Maryland | Montgomery Rockville 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 20853 United States 12610 Grace Max Street Funeral 14 Bace - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 XYes 2 No If Yes, Give Year or Dates: WW II 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2X No Specify: þ White 3 Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) City and County Elementary/Secondary (0-12) College (1-4or 5+) 12 Governments Civil Engineer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Iva Miller Bernie Armentrout 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Brenda K. Armentrout-Daughter 18517 Grape Vine Way, Olney, Maryland 20832 20b. Place of Disposition (Name of cemetery, crematory or other place)
Gate of Heaven
Cemetery Date 20c. Location - City or Town, State 20a. Method of Disposition October 2, 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. 4 Donation 5 Dother (Specify) 2007 Silver Spring, MD 21. Signature of Funeral Service Acenses 22. Name and Address of Facility DeVol Funeral Home, 10 E. Deer Park Drive, Gaithersburg, MD 20877 23a. Part.) et le disease, or complications that caused the ceath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock of et failure. List only one cause on each line.

Immedia Trais (Figure 1)

a. Myocardial Infarction

a. Myocardial Infarction Approximate Interval Between Onset and Death Minutes Physician /Medical Due to (or as a consequence of): Examiner Years Cardiovascular Disease Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner death certificate be executed Years Diabetes burial-tran Due to (or as a consequence of): physician Physician/Medical Hypertension the. ast e esn IF FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year for Day 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a detached f 9 Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 ☐ Yes 2 No 3 Probably 4 MUnknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performed? 1☐ Yes 2 🙀 No certificate Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐ Yes 2[X]No 2 X ER/Outpatient 3 DOA P 1 Inpatient this After th funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Medical Certification: ospital or Attending I 5 Pending investigation Injury 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Hospital 1 🛛 🚅 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only

30+1

Baltimore, Maryland 21215-0036

P.O. Box 68760,

Records,

Division or Vital

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year) OCT 02 2007

29b. Signature and title of certifier



and manner stated.

VIII)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29d. Date signed (Month, Day, Year)

200

			, roi	partment of Health and Nertificate of Death		ene g. N2 0 (7	33059
	Physici	an	Decedent's Name (First, Middle, Last)		2. Date of Death Month		Year	3. Time of Death
	Physici /Media	ai	LOIS MARIE ADAMS	1 0 T	SEPTEMBER	24 2	2007	8:05 A _M
	Examir	er	4a. Facility Name (If not institution, give street and number) CHESTERWYE CENTER	4b. City, Town, or Location of Death GRASONVILLE		4c. County QUEEN		,1 c
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda		8. Date of Birth (Month, Day,			ace (State or Foreign
	Director		220-76-0039 1 M 2 TF 64 Yrs.	Worth's Days Flours War.	DECEMBER 2		MAR	ÝLAND
	/land		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or	Location			10	d. Inside City Limits
	e-fet	ctor	MARYLAND QUEEN ANNE'S GRASONVI	LLE				1 ☐ Yes 2 X No
	or 28	Dire	10e. Street and Number	10f. Zip Code		g. Citizen of V		•
	99th v 18 238	erai	111 CHESTERWYE LANE 11. Marital Status 12. Was Decedent Ever in U.S. 1	21638 3. Was Decedent of Hispanic Origin? (Sp		UNITED	STATE - America	
21215-0036	be filed within 72 hours after deeth with the Maryland hat Hygiene. ed other than "naturel", or items 23a or 28e-f ehow event, the Madical Examinar must be notified at	by Funeral Director	Armed Forces? 1 Never Married 2 Married 1 Yes 2 No HYes, Give Year or Dates:	If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ▼ No Specify:	Rican, etc.)	Blac	k, White, e	tc.
2-0	72 ho	Completed	15. Decedent's Education 16a. De (Specify only highest grade completed) (G	cedent's Usual Occupation we kind of work done during most of work	ring	6b. Kind of Bu	siness/Indi	ıstry
121	within ene. then *	mpl	Elementary/Secondary (0-12) College (1-4or 5+)	. DO NOT use retired)		понски	PRDTW	•
Q 0	e filed within al Hygiene. I other then '		0 JAN	18. Mother's Nam		HOUSEKE faiden Sumam		7
Maryland	should be nd Mental marked c	To Be	PAUL EMMETT ADAMS	LOLETTE	SPITTLE			
lary	2 shoul and M is marl aumati	7	19a. Informant's Name/Relationship (Type, Print) 19b. Ma	iling Address (Street and Number or Rur	al Route Number,	City or Town,	State, Zip	Code)
	s 1 end 2 should f Health and Mer item 27 is marke other traumatic			SCOTTS MANOR DRIVE				
nor	Pages nent of h		143 Dullat 2 Coloniation 5 Chambra non State	rematory or other place)	MBER 26	20c. Location -	-	
Baltimore	글 원립증 .			MEMORIAL PARK 20 22 Name and Address of Eacility	-22-	ASTON,		
ä	Depermine Deperm		& Lif M. Hili	22 Name and Address of Facility FELLOWS, HELFENBEIN 106 SHAMROCK ROAD,	CHESTER,	NAM FUN MARYLA	NEKAL AND 21	HUME, P.A. 619
H			23a. Part1. Enter the disease, or complications that aused the death. Do not shock, or heart failure. List only one cause on agon line.	enter the mode of dying, such as cardiac	or respiratory arre	est,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition regulting in death)	o thruve				Onset and Death
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ő,	be executed icien and burial-transit	Exa	resulting in death) Last Due to (or as a consequence of):					
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Box 6	res that the death certificate igned by the attending physbe detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy			23d. Dat	e of deliver	у
B.	death	sicia	1 ☐ Yes 2 ☑ No 4 ☐ Pregnant at time of death	B □Ectopic pregnancy Diagram (specify)		Moi	nth [Day Year
P. O.	The law requires that the ate hes been signed by the page 2 should be detache	Phy	3 DUKNOWN	underheing equen groon in Bert 1	22a Did tob	2000 USA CONT	ributa to the	cause of death?
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Records,	w require been si should t	Completed			24a. Was ar			sy findings available
Re	The lay te hes age 2	omp			autopsy	ned?	prior to com death?	pletion of cause of
ita	lan: rtifica ctor, p	BeC	25. Was case referred to medical examiner?	26. Place of Deat	1 ☐ Yes 2 h Check only one		162	Chertowyk
<u>></u>	hysic this ce	P	1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpat		me 5 Reside			Assntzal
Division of Vital	To the Hospital or Attending Physician: The within 24 hours after death. To the Funerel Director: After this certificate hy completely filled in by the funeral director, page	Certification:	27. Many of Death 1 Natural 5 Pending (Month, Day Year) 2 Accident investigation		28d. Describe ho	w injury occurr	red	Kury
Visi	Attend r death ctor: /	ifica	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm,		281. Location (Str		er or Rural	Route Number,
Ö	tal or	Cert	4 ☐ Homicide building, etc. (Specify)		City or Town	, State)		
	the Hospital or Attending 24 hours after death the Funerel Director: npletely filled in by the	Medicai	29a. Certifier (Check only Medical Examiner: On the basis of examination and/or	ath occurred at the time, date and place, investigation, in my opinion, death occur	and due to the ca red at the time, da	use(s) and ma	nner as sta	ited. the cause(s)
	To the vithin 2 To the comple	Med	one) and manner stated. 29b. Signature and title of certifier	29c. License number	29	d. Date signed	d (Month, E	Pay, Year)
	- 31-0		8. EDvare MD	D0061688		09/25	5/200	7
	405)		30. Name and address of person who completed cause of death (Item 23a) (Typ		A4 C	211	10	
				ato Drive thenh	or MC	0 016	19	
	Sta Registr	_	31. Date filed (Month, Day, Year) 32. Registrar's Signature					
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2007 33060

Kerry Rustum Ali,		For State	State	of Maryland /	Depart	ment of ficate of	Health an	d Mental F			01 3306
	R	egistrar . Decedent's Name	/First Middle I a	est)	Certii		Death		Reg. 2. Date of Death		3. Time of Death
Physician I Examine		KERRY	RUSTUM						Month Cotober 5, 2	ear 2007	0939 hrs
			f not institution, gi	ive street and number)		. 4		Location of Dear	th	4c. County of Dea	
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Funeral	:	. Social Security N	lumber 6. S	Sex 7. Age	e (In yrs. lasi	t birthday)	If Under 1 Year Months Day		in.	(MM/DD/YYYY) 9. B Fore	ign
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w any	ı,	10a. State	10b. County		,						1 Yes 2 X No
-f sho	호	MD 10e. Street and Nu		Georges	Seat	t Ples	10f. Zip Code		100	. Citizen of What Co	ountry?
Mary Mary ed at	Director	ive. Street and Nu	mber						i	USA	
23a o		7107 Fr	esno St.	12. Was Decedent	t Ever in U.S	. 13. Wa	2074 as Decedent of H	spanic Origin? (Specify Yes or No-	14. Race - Am	erican Indian, Black,
ath wi	Funeral	1 X Never Marri	ed 2 Marrie	Armed Forces		lf Y	es, specify Cuba	n, Mexican, Puer	rto Rican, etc.)	White, etc.	
", or		3 Widowed	4 Divorce	1 Yes 2			Yes 2 X N				Black
ours af	a	15. Decedent's E	ducation (Specify	only highest grade cor	mpleted)	16a. Deceder	nt's Usual Occup	ation (Give kind o e. DO NOT use r		16b. Kind of Busines	s/Industry
72 ho	활	Elementary/Sec	ondary (0-12)	College (1-4 or		_				Kerry's A	Autobody
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15-C filed v I Hygi ed oth		17. Father's Name Kerry Fa							y Henders		
212. Ild be Menta marke even!	To Be	19a. Informant's N				19b. Mailin	g Address (Str	eet and Number	or Rural Route Num	per, City or Town, St	ate, Zip Code)
2 shou and I	-		Ali/Si					1 Ave #3		e,MD 2072	
e, N l and l Health item	l	20a. Method of Dis	sposition	- 🗆 - 16 0		lace of Dispo rematory or o	sition (Name of o ther place)	emetery,	Date	20c. Location - City	or Town, State
nor ages lant of lat: If	ļ	1 XBurial 2	Cremation Other Spec	3 Removal from S		rv1and	Nationa	al Cem 1	0-12-2007	Laurel,	MD.
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.	ŀ	21. Signature of F	uneral Service Lic	censee		²² M	Name and Addre	ss of Facility ineral H	ome		
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hysician		23a. Part I. Enter	the disease, or co nly one cause or	implications that cause a each line.	ed the death.	Do not enter	the mode of dyin	g, such as cardie	ac or respiratory arre	ot, one on, or mean	Between Onset and Death
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COF law r has b	Completed									ormed? dea	th? Yes 2 No
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/iSic r Atte ter der irecto n by t	fica	2 Accident 3 Suicide	6 X Could	igation 28e. Place o			reet, factory, offi	ce building, etc.	or Town,	State) /1()/ Hin	or Rural Route Number, City
Divisior pital or Attend ours after death eral Director:	Certification:	4 Homicid	e deterr	1 (-///	resid				Seat Ple		County, Mil.
Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Paneral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the b		29a. Certifier 1 (Check only	Certifying Ph	ysician: To the best o	f my knowled	dge, death oc and/or investi	curred at the time	e, date and place nion, death occu	e, and due to the cau rred at the time, date	ise(s) and manner as and place, and due	to the cause(s)
To the Hos within 24 h	Medical	1		and mariner state	ed.			cense number		29d. Date signed	(Month, Day, Year)
	≥	29b. Signature a	and title of certifier	, mp				.C.M.E.		October 6, 2	007
		,	1		-1	- 03a)					
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ORIGINAL

State of Maryland / Department of Health and Mental Hygieney State Registrar Amend #12.perFD, 0873, 11/29/07 TTCertificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death sept. 25 pay 2007 ear **Physician** enon 2345 (007 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Rockville Montgomery Shady Grove Adventist If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 6 Sex **Funeral** Min. 3/19/1927 Months Days Hours 265-28-8323 1X M 2 □ F Alabama 80 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mertal Hygiene. and the filem 27 is marked other than "natural", or items 23a or 28a-f show ant: If item 27 is marked other than "natural", or items 23a or 28a-f show uny or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Montgomery Village MD Montgomery 1 XYes 2 No Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20886 USA 20419 Remsbury Place Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Xes 20 No If Yes, Give Year or Dates: 1X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo White Specify Specify: Completed by 3 Widowed 4 Divorced 1945 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Real Estate Realtor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Lella Hart Dennis Adkison ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3 Valley View Lane Newton Square, PA. 19073 Paula McEvoy/Niece 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation / → □ Removal from State 10/01/2007 Silver Spring, Md. important: If any Injury or once. Gate of Heaven 4 □Donation 5 □ Other Specify) 21. Signature of Funeral Se PATTIP AD TO ATTINATION FUNERAL SERVICE, P.A. 9241 Columbia Blvd.Silver Spring,Md20910 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Cardiac Arrest disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Cardiac Arrhythmia Sequentially list conditions, liany Lating to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of The law requires that the death certificate be executed Ischemic Heart Disease attending physician and for use as the burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? Month Day 5 ☐ Other (specify) signed by the aid be detached for 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has t irector, page 2 s autopsy performed? 1 Yes 2√2 No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? funeral director Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 1 XInpatient 2 ER/Outpatient 3 DOA this Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 5 Pending investigation Injury 1 Natural 1 ☐ Yes 2 ☐ No М ours after death.
neral Director: # 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D0065478 Sept. 27, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9901 Medical Center Dr. Rockville, Md 20850 Mohhammad Sanaei MD 31. Date filed (Month, Day, Year) 32 Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

01

2007

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** 21, SEPTEMBER CHARLES BROWN. JR. 2007 7:00A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** CAPITOL HEIGHTS PRINCE GEORGES 6892 WALKER MILL ROAD If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country)
November2,1955 Maryland 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours Days 1 ☐ M 2 ☐ F 214 60 2777 51 Director Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. em 27 is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10b. County 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1∏Yes 2∏No Director Maryland | Prince George's Capitol Heights 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6892 Walker Mill Road 20743 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black White etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify ģ Specify: Black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) UNEMPLOYED NONE 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Charles E. Brown, Sr. Mary Francis Brown ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 a Department of Health ar Important: If item 27 is Marguerite Brown/Sister 6892 Walker Mill Road Capitol Heights, MD injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Metropolitan Crematory 10-1-2007 Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee

**TONIC TONIC TON 2. Name and Address of Facility MARSHALL'S FUNERAL HOME OF MARYLAND, INC. any ir 4308 SUITLAND ROAD SUITLAND, MD 20746 Gart 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 4therose Physician 5-63-0 /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) The law requires that the death certificate be executed the burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 ☐ Other (specify) the 9 Unknown þ cate has been signed in page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 | Yes 2 | No 3 | Probably 4 | Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed certificate 2 No Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one, Other: 4 Nursing Home 5 Pesidence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA Medical Certification: To 1 ☐ Inpatient After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? or Attending Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. 2 Accident investigation within 24 hours after death To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide Hospital 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated completely 22 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year, cause of death (Item 23a) (Type, Print) 30. Name and address of person who completed 32. Registrar's Signatur 31. Date filed (Month, Day, State 2

DHMH 17 Rev 1/2001

Registrar

State of Maryland / Department of Health and Mental Hygiene Reg. 2.00 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** September 26, 2007 11:03 AM Eunice E. **Bullard** /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince George's Takoma Park 902 Conley Road If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 3-28-1925 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In vrs. last birthday) Funeral^{*} 1□M 2XF 82 Waycross, GA 256-36-7474 Director Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours after death with the Maryland 10c. City. Town or Location 10a. State 10b. County r than "natural", or itams 23a or 28e-f ahow the Modical Examinar must be notified at MD Prince George's Takoma Park 1X Yes 2 No Completed by Funeral Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20912 902 Conley Road United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ऒ No If Yes, Give Year or Dates: 11, Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No White Specify: Specify: 3 X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Sales Clerk Private . Peges 1 and 2 should be filed v tment of Health and Mental Hygie tant: if Itam 27 is marked other t jury or other traumatic svent, in 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Melissa Griffis Preston Powell ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 8701 Lanham, MD 20706 Judith L. Gordon (daughter) Old Browns Lane 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 10-1-2007 1 ☐ Burial 2X Cremation 3 ☐ Removal from State permit. Pege Depertment of Important: if any injury or once. Fort Lincoln Crematory Brentwood, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Fort Lincoln Funeral Home 21. Signature of Funeral Service Licensee 3401 Bladensburg Road 20722 Brentwood, MD Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) Metastatic Lung Cancer /Medical Due to (or as a consequence of) Examiner Conary Artery Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine physician and s the burial-transit The law requires that the death certificate be executed Breast Cancer Due to (or as a consequence of): Records, P.O. Box 68760. Chronic Obstructive Pulmonary Disease Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Year Month ŏ Day 4 Pregnant at time of death 5 Other (specify) signed by the aid be detached for 1 ☐ Yes 2 No the 9 Unknown ģ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? res 20 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes Division of Vital To the Hospital or Attending Physicien: within 24 hours after death.

To the Funerel Director: After this certifical 25. Was case referred to medical examiner?
1. Yes 2 □ No Be 26. Place of Death Check only one Other: Hospital: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 5 28c. Injury at Work? To the Funerel Director: After th completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 27. Manner of Death Certification: Injury 1X Natural 5 Pendina 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Stull D 0046998 9/28/2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Steven Tee, MD 3415 Hamilton Street Suite 1 Hyattsville, MD 20782 Steven Tee, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Registrar

State of Maryland / Department of Health and Mental Hygiene 33065 Reg. No 2 0 0 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** September 29, Elizabeth Ann Boisclair 2007 7:40a M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Adelphi Hillhaven Nursing Center Inc. Prince George's

9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** Days Months Hours 1 M 2 X 577-50-6724 92 Director Jan. 12, 1915 Maryland Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County s 23a or 28a-f show nust be notified at show 1 Yes 2 No Director Maryland Prince George's Glenn Dale 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Examiner must be 7405 Epling Road 20769 USA death v Funeral tems 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black White etc. 72 hours after 1 ☐ Yes 2 🕱 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 'natural", or 1 ☐ Yes 2 ☑ No Specifwh ite 9 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. filed within Elementary/Secondary (0-12) College (1-4or 5+) the 5+ Teacher Public Schools permit. Pages 1 and 2 should be filed to Department of Health and Mental Hyglic Important: If item 27 is marked other I any Injury or other traumatic event, the 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ernest Jett Annie Elizabeth Collins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia Reuss/ Daughter 7405 Epling Road, Glenn Dale, MD 20769
sition (Name of Date 20c Location - City or Town S Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State October 2, Rock Creek Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Washington, DC 2007 21. Signature of Funeral Service Licensee Francis J. Collins Funeral Home Inc. 500 University Blvd, W. Silver Spring, MD 20901 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications shock, or heart failure. List only one tions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ause on each line Immediate Cause (Final disease or condition resulting in death) **Physician** Multi-lobar Pneumonia /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Gause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine and burial-trar Due to (or as a consequence of): Box 68760, physician pe Physician/Medical the IF FEMALE: use If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4□Pregnant at time of death 5 Other (specify) P.O. the a∏Unknown 9 Unknown by signed by be detail Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Hypertension, Osteoporosis, Osteoarthritis, Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 s Cerebrovascular Disease certificate has autopsy 1∐ Yes 2K No Division or Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2X No 1 Inpatient 2 ER/Outpatient 3 DOA 2 this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 To the Hospital or Attending I within 24 hours after death.
To the Funeral Director: After Certification: 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation 2 Accident the 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide filled in 🎦 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated 29c. License number 29b. Signature and title o 29d. Date signed (Month, Day, Year) d55559 October 2, 2007 MD. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7525 Greenway Center Drive, #316, Greenbelt, MD 20770 Thomas Maslen, M.D. 32 egistrar's Signature

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Registrar

31. Date filed (Month, Day, Year)

OCT

02

2007

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** Berry 2007 Morrell October 1, 10:50 Joseph /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 13805 Parkland Drive Montgomery Rockville If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 ★ M 2 🗆 F Director 86 Feb. 27, 1921 Pennsylvania 577-18-4469 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits show 10a. State 10b. County an "naturai", or Items 23a or 28a-f shov Medical Examiner must be notified at 1 ☐ Yes 2 No Maryland Rockville Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 13805 Parkland Drive 20853 USA death v Funeral 14 Bace - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. nt: If item 27 is marked other than "natural", or Ite 1 ☑ Yes 2 ☐ No If Yes, Give Year or DatewwII 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: White þ 3 Nidowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) the 12 Estimator Moving Company traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary M. Munis Morrell Thomas Berry 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1633 16th Street, NW, Washington, DC 20009 John Berry/ Son other t Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition October Department of h Important: If ite any injury or of once, 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2007 Metropolitan Crematory Alexandria, Virginia 21. Signature of Funeral Service License 22. Name and Address of Fac Francis J. Collins Funeral Home Inc. 500 University Blvd, W, Silver Spring, MD 20901 Part1. Enter the disease, or com, lica ions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only a legislation and line. Approximate Interval Between Onset and Death 23a. Part1 Immediate Cause (Final disease or condition resulting in death) **Physician** Myocardial Infarction Acute /Medical Due to (or as a consequence of) Examiner Ischemic Heart Disease Chronic Sequentially list conditions, if any Leona to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-trai Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 attending physician for use as the huria Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a 9 Unknown 9 Unknown been signed by should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Hypertension, Hyperlipidemia, Arthritis, ASCVD Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy perform 1∐ Yes 2 No Hospital or Attending Physician: funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 X Yes 2 □ No 1 Inpatient 2 ER/Outpatient 3 DOA P 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No nours after death.

neral Director: / 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 124 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the I 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D27301 October 2, 2007 soften (S 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 615 W. Montgomery Avenue, Rockville, MD 20850 Douglas Shumaker, MD 31. Date filed (Month, Day, Year)

OCT 0 2 2007 Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 2007 Certificate of Death 1. Decedenț's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Year **Physician** 9 30 2007 /Medical 4b. City. Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Shady Montgomery Grove Hospital Rockville 7. Age (In yrs. last birthday If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 1 ☐ M 2 🔀 F unavailable 72 Director 12/01/1934 Bangladesh Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits ral", or Items 23a or 28a-f show Examiner must be notified at Montgomery 1 ☐Yes 2 No Director MD Potomac 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20854 7 Woodsend Pl. Bangladesh Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married 7 is marked other than "natural", or i traumatic event, the Medical Examir altimore, Maryland 21215-0036 1 ☐ Yes 2X No þ Specify: Asian 3 X Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mental Hygiene.
Important: If Item 27 Is marked other than "na any injury or other traumatic events." Elementary/Secondary (0-12) College (1-4or 5+) Housewife Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Wazed Ali Sarkar Khodeja Khatun 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Iraj H. Talukder- son 7 Woodsend Pl., Potomac, Md. 20854 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 N Burial 2 □ Cremation 3 Removal from State Family Cemetery 4 □ Donation 5 □ Other (Specify) 10/5/07 Dhaka, Bangladesh 22. Name and Address of Facility Universal Mortuary 21. Signati Juneral Servi 411 Kennedy St., N.W. Washington, DC 20011 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** wur /Medical consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Die to (or as a consequence of) attending physician and for use as the burial-tran (or as a consequence of P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 □Ectopic pregnancy Month 4□Pregnant at time of death 5 Other (specify) 9 Unknown been signed by should be detach Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No s certificate has the lirector, page 2 s autopsy performed⁴ 1∐ Yes 2 X No or Attending Physician: 25. Was case referred to medical examiner? director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes No Certification: To 1 ☐ Inpatient 2 → R/Outpatient 3 □ DOA funeral Manner of Death 28a Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 ☐ Pending investigation (Month, Day Year) ours after death.

neral Director: A
filled in by the fu 1 Yes 2 No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital within 24 hours a To the Funeral C Hospital 29a. Certifier 1 🔯 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar

Nicole Vetere 31. Date filed (Month, Day, Year) 02

29b. Signature and title of certifier



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



29c. License number

29d. Date signed (Month, Day, Year)

20850

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** OCTOBER 2007 11:06 A BOWMAN HAROLD EUGENE /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner WASHINGTON 21265 MT. LENA ROAD BOONSBORO | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | FEB. 9, 19 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In vrs. last birthday **Funeral** 1 XM 2□ F 74 MARYLAND 217-32-6073 Director Usual Residence of Decedent 10d. Inside City Limits 10a State 10h. County 10c. City, Town or Location show ral", or items 23a or 28a-f shov Examiner must be notified at 1 ☐ Yes 2 ☐ No Director MARYLAND WASHINGTON **BOONSBORO** 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21713 U.S.A. 21265 MT. LENA ROAD by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 12 Yes 2 □ No1 953 − If Yes, Give Year or Dates: 1955 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. within 72 hours after 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: Specify. 3 Widowed 4 Divorced WHITE "natural", Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) than College (1-4or 5+) CUSTODIAN COUNTY BD OF EDUCATION and 2 should be filed w lealth and Mental Hygie m 27 is marked other ti 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be CHARLOTTE MAE SCHILDT IRA GLENN BOWMAN ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2: Department of Health ar Important: If item 27 is any injury or other trau 21265 MT. LENA ROAD, BOONSBORO, MD LORRAINE BOWMAN, WIFE Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 Donation 5 ☐ Other (Specify) BOONSBORO CEMETERY 10/6/2007 BOONSBORO, MARYLAND 21. Signature of Fineral Senice 22. Name and Address of Facility 7606 OLD NATIONAL PIKE BAST FUNERAL HOME BOONSBORO, Dean Paul Μ. 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 29 uhanous **Physician** /Medical resulting in death) s a consequence of): Examiner quantially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine wome certificate be executed Due to (or as a consequence of) Box 68760. attending physician Physician/Medical as the nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 ☐ Ectopic pregnancy 1 ☐ Live birth Month for Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) P.0. 1 ☐ Yes 2 ☐ No ed by the a 9☐Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, þ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2□No 1 🗆 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Sesidence 6 Other (Specify) ġ. 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA ဂ္ filled in by the funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No i or Attend after death Director; 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours a Hospitai ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

5H-8+1

within 2

State Registrar 31. Date filed (Month, Day, Year) OCT 0 5 2007

29b. Signature and title of certifier

e of death (Item 23a) (Type, Print)

CES, MD WY OPAL COUFT, HACTERSTOWN

MD 217 30. Name and address of person who completed co 32. Degistrar's Signature

and manner stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2007 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** Seplember 29 2007 Ada Marie Burton /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number, Examiner ambridge Dorches Dorchester General If Under 1 Year | If Under 24 Firs. Birthplace (State or Foreign Country) 5. Social Security Number Date of Birth (Month, Day, Year) **Funeral** Hours 1 □ M 2 □ XF 215-20-1718 85 June 22, Director 1922 Maryland Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits r 28a-f show notified at show Yes 2 No Director MD Dorchester Cambridge 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a or 2 Iner must be n 503 Muir St., Apt. 211 21613 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. r than "natural", or iter the Medical Examiner 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🔀 No Specify. white Be Completed by 3 Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) own home 8 homemaker ages 1 and 2 should be filed vent of Health and Mental Hygie nt: If item 27 is marked other ty or other traumatic event, the 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Maryland Ernest G. Guthrie Enid Corbin 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 5618 Hicksburg Rd., East New Market, MD William G. Burton son 21631 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Pages 1 1X Burial 2 □ Cremation 3 □ Removal from State permit. Page Department of Important: If any Injury or 4 ☐ Donation 5 ☐ Other (Specify) 10/3/07 Dorchester Mem. Park Cambridge, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Thomas Funeral Home P.A. 700 Locust St., Cambridge, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) MyocardizI inavera Acute **Physician** /Medical Due to (or as a consequence of): Examiner Mulhorger Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Sepsis that the death certificate be executed burial-tran Due to (or as a consequence of): physician Physician/Medical the IF FEMALE: nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a o 9 Unknown 9 Unknown ٦ signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performed? certificate 2 HNO Vital 25. Was case referred to friedical examiner? funeral director 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient Medical Certification: To 1 Yes 2 100 2 ER/Outpatient 3 DOA or this 27. Man of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After Division Hospital or Attending 1 Natural 5 Pending n 24 hours after death.

Per Funeral Director: Af pletely filled in by the ful 1 Yes 2 No investigation 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. within 2. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 10.2-07 30. Name and address of person who completed buse of death (Item 23a) (Type, Print) 710 CAMBRIDGE 503 NIOMAN BYRN THANNT

DHMH 17 Rev 1/2001

Registrar

31. Date filed (Month, Day, Year)

32. Regiorar's Signature

State of Maryland / Department of Health and Mental Hygiene, 33070 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death OCTOBER **Physician** BEECHER **BUTTS** 2007 12:40 P M RUFUS /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Mount Airy Howard Our Family Assisted Living 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1**52** M 2□ F 578-09-6392 95 Director June 25 1912 Oklahoma Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a State 10b County 10c. City, Town or Location 10d, Inside City Limits "natural", or items 23a or 28a-f shovidical Examiner must be notified at 1 ☐ Yes 2 No Gaithersburg Director Md. Montgomery 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 20882 4015 Damascus Road United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: Specify: Completed by White 3 Widowed 4 □ Divorced 7 is marked other than "nature traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Camp Director Recreation 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Cook Nettie Rutherford ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If Item 27 is 1 any Injury or other traur once. 4025 Damascus Road, Laytonsville, Md. 20882 Marian J. Staehle / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 Na Cremation 3 ☐ Removal from State 10/2/07 Alexandria, Va. 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crem. 22. Name and Address of Facility
Muriel H. Barber Funeral Home 21. Signature of Funeral Service Licenses P. O. Box 5038, Laytonsville, Md. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Pneumonia 1 Week /Medical Due to (or as a consequence of): Examiner 3 Years Alzheimers Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner The law requires that the death certificate be executed burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760. physician the as F FEMALE nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Atrial Fibrillation 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Coronary Artery Disease 24a. Was an page 2 autopsy 1□ Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical examiner? director. Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Dother (Specify) SSt. Living 1 ☐ Yes 2 No Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural Injury 1 □ Yes 2 □ No 2 Accident s after death. 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide filled in within 24 hours a

To the Funeral I

completely filled 1⊈ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

DHMH 17 Rev 1/2001

State

Registra

ma

501 N.

32 Registrar's Signature

30. Name and address of person who completed cause of death (xem 23a) (Type, Print)

Marlene T. Hayman, M.D.

03

31. Date filed (Month, Day, Year)

OCT

D-31362

Frederick Ave., Gaithersburg, Md.

October 2, 2007

20877

	State of Maryland / Department of Health and Mental Hydrograms 1 - State Registrer Certificate of Death									Hygiene	2001	33071	
Physicia /Medic		n al -	1. Decedent's Name (First, Middle, L JAI	2. Date of De Month			09 Day	Part Pay 26 Year 7:05AM					
Exa	amine			lical Cent	er	ast birthday)	4b. City, Town, or Annapol If Under 1 Year	is If Under 24	t Hrs. 8. Date	An:	ne Aruno 9. Birt	iel	
Direc	tor		555-54-9519 Usual Residence of Decedent 10a, State 10b, County	№ 2 F	64	Yrs.	Months Days	Hours	Min. 6/2	247Y943	Co	hplace (State or Foreign unity) CA 10d. Inside City Limits	
the Maryla									10q. Cit	1 ☐ Yes 2√2 No 10g. Citizen of What Country?			
ire, Maryland 21215-0036 s.1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 271 marked other than "natural", or items 23a or 28a-f show	to Company	by Funer	50 K Greystone Ct. 11. Manital Status 1 Never Married XX Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2000 No If Yes, Give Year or Dates:				21403 . Was Decedent of Hispanic Origin? (Specify Yes or No- iff Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes XXNo Specify:				USA 14. Race - American Indian, Black, White, etc. Specify: White		
21215-0036 sd within 72 hours aff giene. er then "naturel", or	Lie Medical	Completed	(Specify only highest grade completed) (Give kind life. DO Ni				kind of work done of DO NOT use retired	nd of work done during most of working NOT use retired)			b. Kind of Business/Industry		
Maryland 2 d 2 should be filed th and Mental Hygi R7 is marked other	To Do O	Re	17. Father's Name (First, Middle, Las Robert Barton 19a. Informant's Name/Relationship					18. Mother:	s Name (First, M	Middle, Maiden	Sumame)		
Baltimore, Maryland 2121 permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 271s marked other than your intervent the state of the st	y or other traus	- 1-	Brenda Griffey Ba 20a. Method of Disposition 1	rton Wi	20b. P	50 K (lace of Dispo	ng Address (Street a Greystone sition (Name of natory or other place t Cemeter	Ct.	Annapol Date 29/2007	Lis, MD		Town, State	
Dermit. P Departme importan	any mjur		21. Signature on Fune yal Service Lice			22	Name and Addres	s of Facility	Hardest	y Funer	ral Home		
Cate be executed Cate be executed Physician and The burial-transit	cal ner	=	23a. Part1. Enter the disease, or of mplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):								Interval Between Onset and Death		
the death certification of the attending	or use as	Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify)							23d. Date of delivery Month Day Year		
quires that the signed by unid he detact		2	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23e	23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Onknown			
	raffer d		25. Was case referred to medical							. Was an autopsy performed? Yes	prior to completion of cause of death? s 1 Yes 2 No		
dang Atte	100	0	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigate 3 Suicide 6 Could not	jury Pa <i>y Year)</i>	ER/Outpatient 3 DOA Other: 4 Nursing Hom 28b. Time of Injury 28c. Injury at Work? 1 Yes 2 No			28d. Des	ne 5 Residence 6 Other (Specify) 8d. Describe how injury occurred 8d. Location (Street and Number or Rural Route Number,				
DIVISION To the Hospital or Attanwithin 24 hours after deat To the Funeral Director: Completely filled in by the	on med my		determined 286. Place of Injury - At nome, farm, street, factory, office 281. 1							City or Town, State)			
To the Hospital within 24 hours a To the Funeral I	Town In the second		29b. Signature and title efficient/fier Duslum, MD 29c. License number 29d. Da D65635							ate signed (Month, Day, Year)			
S CH	State		30. Name, and address of person who will be seen a seen and address of person who will be seen a seen and address of person who will be seen a seen and address of person who will be seen a seen and address of person who will be seen a seen and address of person who will be seen a seen and address of person who will be seen a seen and address of person who will be seen a seen and address of person who will be seen a seen and address of person who will be seen a seen and address of person who will be seen a seen and address of person who will be seen a seen and address of person who will be seen a seen and address of person who will be seen as a seen a seen a seen and address of person who will be seen a seen and address of person who will be seen a seen and address of person address of person and address of person and address of person address of	9CIN, MD 32. Pagis	trar's Signat	NNAP	OUS ON	DIOG	Y CENT	12,900 118, M	BB1214	TTERD, STE	

DHMH 17 Rev 1/2001

Division or Vital Records, P.O. Box 68760,

State Registrar

31. Date filed (Month, Day, Year) 01



Librie Hemi- Tumuicosi

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. LIBUSE HEINZ-HOMEICOVIC, 10605

2007

00058546

29d. Date signed (Month, Day, Year) SEPTEM BER 27,2007

CONCORD STREET #500, KENSINGTON, MO

Registrar

State

RUTH BERNSTEIN

WARIE

30 Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 2007 4:08 P October 6 Elizabeth Florence Cress 4c. County of Death 4b, City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Annapolis Anne Arundel Anne Arundel Medical Center 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 1 □ M 2 🛛 F Yrs. 02-03-1934 Pennsylvania 73 213-56-4113 Usual Residence of Decedent 10d, Inside City Limits 10c. City, Town or Location 1X Yes 2 No North Beach Calvert 10g, Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 20714 8821 Frederick Avenue 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: white 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)

laundromat manager

So. Memorial Gardens 10-10-2007

22. Name and Address of Facility

20b. Place of Disposition (Name of cemetery, crematory or other place)

commercial laundry

20c. Location - City or Town, State

Approximate Interval Between Onset and Death

Dunkirk, MD

18. Mother's Name (First, Middle, Maiden Surname)

9019 Chesapeake Ave., Apt. 17, N. Beach MD 20714

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Date

Ella

Elizabeth Boord

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

ral", or Items 23a or 28a-f show Examiner must be notified at

death

and 2 should be filed within 72 hours after of ealth and Mental Hygiene. n 27 Is marked other than "natural", or Iter

Pages 1

event, the Medical

other traumatic

3altimore, Maryland 21215-0036

Director

Completed by

Be

2

MD

11. Marital Status

17. Father's Name (First, Middle, Last)

Durst,

Kimberley D. Allen, daughter

1 X Burial 2 ☐ Cremation 3 ☐ Removal from State

19a. Informant's Name/Relationship (Type. Print)

4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses

Jacob P.

20a. Method of Disposition

burial-trai physician the as nse for been signed by the should be detached page 2 s certificate director. funeral After death. Ifter death

The law requires that the death certificate be executed

P.O. Box 68760,

Division or Vital Records,

To the Hospital or Attending Physician:

Department of Health ar Important: If Item 27 Is any Injury or other trauonce. Rausch Funeral Home, P.A. 8325 Mt. Harmony Lane, Owings, MD 20736 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) encephaloparth anoxic Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) 9∏Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 24a. Was an perform 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 1 Yes 2 No 1 Impatient 2 ER/Outpatient 3 DOA Certification: To 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 1-Natural 5 Pending Iniury 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours

To the Funeral Completely filled 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier

23d. Date of delivery Day 23e. Did tobacco use contribute to the cause of death? 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1- Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 10/6/7 address of Person who completed cause of death (Item 23a) (T 32. Registrar's Signature 31. Date filed (Month, Day, Year) 6 2007

10

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 4:30 PM /Medical Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Nursing Rehab Kensington Montgomeny If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 M 2□ F Months Days Hours 243-50-5171 70 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a State 10h County 28a-f show r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 Yes 2 □ No **Funeral Director** 10g. Citizen of What Country? 10e. Street and Number HUNIE 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married Married Baltimore, Maryland 21215-0036 2 No 1 ☐ Yes Specify: Be Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. int: If item 27 is marked other than ' College (1-4or 5+) Elementary/Secondary (0-12) or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7 FH permit. Pages 1 and 2 Department of Health a Important: If item 27 Is any Injury or other tra Washington ma crothy 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 ☐ Cremation 3 ☐ Removal from State Nashville OAKland Cemeter 07/07 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ist only one cause on each line. 23a. Part1. Enter the dise s shock, or heart failur. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Unknown ancen /Medical Due to (or as a cons a) ence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Gause (Lisease of Ilijury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner death certificate be executed burial-tran Due to (or as a consequence of) P.O. Box 68760 attending physician the as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? Month Year 4☐Pregnant at time of death 5 Other (specify) TYPS 2 No 9 Unknown signed by i Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? or Vital Records, Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of Weight loss 24a. Was an autopsy performe death? 1 □ Yes 2 □ No Weakness To the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dir 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 1 Natural 2 Accident 5 Pending investigation 1 🗌 Yes 2 No 6 □Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Chowdly, mo 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DINO DRIVE , BURTONSVILLE CHOWDHURY, MD; 15216 NURUL 32. Registrar's Sign 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

State

Registrar

OCT 0 2 2007

Box 687605

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or Vital

31. Date filed (Month, Day, 2007 gistrar's Signature



Genevieve Wroblewski, M.D., 1355 Piccard Drive, Suite 100, Rockville, MD 20850

Registrar

			1- State Registrar Cer	tificate of L			g. No.2 0 0 7	33077
	Physici	an	Decedent's Name (First, Middle, Last)			 Date of Death Month 	Day Year	3. Time of Death
	/Medic		Betty Jane Kendall Cole			ept.	29 2007	1542 M
	Examin	er	4a. Facility Name (If not institution, give street and number)		Location of Death		4c. County of Dea	
			Washington Adventist Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	Takoma If Under 1 Year		. Date of Birth	Montgom	
	Funeral Director		579-38-5917 1 M 2 M F 7. Age (iii yrs. last bittingy)	Months Days	Hours Min.	(Month, Day,	rear) Co	thplace (State or Foreign ountry)
į,			Usual Residence of Decedent			Dec. 2,	1927 Was	hington, D.O
	yland low		10a. State 10b. County 10c. City, Town or Loc	ation				10d. Inside City Limits
	Mar a-f sh ffied	ż	DC N/A Washing	≥ton				1 ⊈Yes 2 □ No
	h the	irec	10e. Street and Number	10f. Zip Code		10	g. Citizen of What Co	ountry?
	h wit	alD	5125 S. Dakota Ave., N.E.	200	17		U.S	•
	ems er mu	Funeral Director		Vas Decedent of H	ispanic Origin? (Speci an, Mexican, Puerto Ri	fy Yes or No-	14. Race - Ame Black, Whit	
36	be filed within 72 hours after death with the Maryland ital Hygiene. dother than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at	by Fu	1 □ Never Married 2 □ Married 1 □ Yes 2 TX No	I □ Yes 2 🖾 No		oan, etc.,	Specify: A:	frican
215-0036	2 hou atura cal E	ed		lent's Usual Occupa	ation	1	6b. Kind of Business	nerican /Industry
212	in 72 In "n Medi	Completed	(Specify only highest grade completed) (Give life. D	kind of work done o O NOT use retired	during most of working f)	'		
212	d with giene ar tha the l	E O	5+ Teac	her			D.C. Gove	rnment
ğ	~ ~ 0 9	Be C	17. Father's Name (First, Middle, Last)		18. Mother's Name (First, Middle, M.	aiden Surname)	
Maryland	should be nd Mental marked o	TOE	George Kendall		Virgini	a Tolli	ver	
aZ		П	19a. Informant's Name/Relationship (Type. Print) 19b. Mailing	g Address (Street a	and Number or Rural	Route Number,	City or Town, State,	Zip Code)
			Paula Cole Jones / Daughter 1605	Crittend	en St., N.	E. Wash	ington, D	.C. 20017
ē	ages 1 and nt of Health if item 27 or other t		20a. Method of Disposition 20b. Place of Disposition	sition (Name of natory or other plac	; Da		0c. Location - City or	
Ĕ	Pages nent of int: If it		I IX Bunal 21 ICremation 31 Internoval from State 1			2007	Suitlan	d. MD
Baltimore,	permit. Page Department of Important: If any Injury or once.		21. Signature of Funeral Service Licensee 22	. Name and Addres	ss of Facility McC	Guire Fu	neral Ser	d, MD vice, Inc.
n	8 3 E 6 5		Undré Thompson 74	100 Georg	ia Ave., N	.W. Was	hington,	D.C. 20012
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each ling.	er the mode of dyin	g, such as cardiac or	respiratory arres	st,	Approximate Interval Between
4	Physician	2 1	Immediate Cause (Final disease or condition	54	nill			Onset and Death
<i>!</i>	/Medical Examiner		Due to (or as a consequence of):	1	cerd cerd			
	LAdillilei	_	Sequentially list conditions, b. 4th ero Sc	lensic	Cerd	100-50	ala disea	e
	ed sit	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that injitated events					
ر ر	xecut and Il-tran	Examiner	that initiated events resulting in death) Last C. Due to (or as a consequence of):					
9	The law requires that the death certificate be executed te has been signed by the attending physician and age 2 should be detached for use as the burial-transit							
68760,	rtificate ng phys as the	Medical	d					
ROX	certir nding use a	J/M	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome pf pregnancy				23d. Date of de	elivery
ň	death cer attendin d for use	cial	in the past 12 months? 1 ☐ Yes 2 ☒ No 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ 4 ☐ Pregnant at time of death 5 ☐]Ectopic pregnancy] Other <i>(specify)</i>	′		Month	Day Year
O.	that the denetation the second to	Physician/	9 Unknown					
ري ت	s thai	by P	Part II. Other significant conditions contributing to death but not resulting in the un	nderlying cause give	en in Part I.	23e. Did toba	acco use contribute t	to the cause of death?
ecords,	w requires to been signer should be					1 ☐ Yes	s 2 □ No 3 □ P	robably 4 □Unknown
ပ္တ	aw re Is be	Completed				24a. Was an		utopsy findings available
ř	sician: The law certificate has l irector, page 2 s	E O				autopsy perform	ned? 🖈 death?	completion of cause of s 2 □ No
Vital K	ian: rtifica ttor, p	Be C	25. Was case referred to medical		26. Place of Death (, 2010
	Physician: r this certificanal director, I	To E	examiner? 1 Yes 2 No Hospital: 1 Impatient 2 ER/Outpatient	t 3 DOA Oth	er: 4 Nursing Hom	e 5 🗆 Resider	nce 6 □Other (Spe	ecify)
סר	ding Pt h. After th funeral		27. Manner of Death 28a. Date of Injury 28b. Time of 1 □ Matural 5 □ Pending (Month, Day Year) Injury	28c. Injur Worl	y at 28	Bd. Describe how	w injury occurred	
Š	endir ath. or: At	atio	2 Accident investigation		Yes 2 □ No			
DIVISION	or Atterder de lirecton by the	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, streething building, etc. (Specify)	et, factory, office	28	of. Location (Str. City or Town,	eet and Number or F State)	ural Route Number,
	oltal curs af							
	To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After the completely filled in by the funera	Medical	29a. Certifier 1 ☐ Certifying Physician: To the best of my knowledge, death (Check only one) 2 ☐ Medical Examiner: On the basis of examination and/or invane) and manner stated.					
	Го th within Го th	Me	29b. Signature and title of certifier	29c. Licens	e number	29	d. Date signed (Mon	nth, Day, Year)
	M			000	60/00	1/	0-01-0	7
,	IA		30. Name and address of person who completed cause of death (item 23a) (Type, I	Print)	21 110	VEN	SITU 11	- VO
_			TAHMINA KAGNED S	IlVEn	SPRIN	v4 1	MD 209	903
	Sta Registi		29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, I) 31. Date filed (Month, Day, Year) 32 Degistrar's Signature	and a				
			- Louis Little Report R					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 2007

	1- For Amend Items State of Maryland / Department of Health and M 23a, Pt II, 25 per me 98/2 10/26/076	ental Hygiei ihb	n2007 33078
	Decedent's Name (First, Middle, Last)	2. Date of Death	Day Year
Physician /Medical Examiner	John Michael Coffey 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death	Septembe	r 26, 2007 10:00P 4c. County of Death
	Holy Cross Rehab and Nursing Center Silver Spring		Montgomery
Funeral Director	5. Social Security Number 6. Sex 1 M 2 F 7. Age (In yrs. last birthday) 1 ft Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Ye April 2.	
and *	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location	-	10d. Inside City Limits
Maryli -f sho	Maryland Prince Georges Laurel		1 Yes 2 □ No
with the Mai tor 286-fs ke rectified	10e. Street and Number 10f. Zip Code	10g.	Citizen of What Country?
th witt	7426 Berryleaf Drive 20707	Un	ited States of Ameri
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Important of Health and Mental Hygiene. Important if item 27 is marked other than "natural, or items 23s or 28e-f show any injury or other treumatic event, it is Medical Exacts or instacts rediffed an once. To Be Completed by Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 12. Was Decedent ever in U.S. If Yes, specify Cuban, Mexican, Puerto 1 ▼ Yes 2 □ No 1 ▼ Yes 2 ▼ No Specify:	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: Caucasian
hour tural tural	3 Widowed 4 Divorced Year or Dates: 1933 16a. Decedent's Usual Occupation	166	. Kind of Business/Industry
Maryland 21215-0036 to 2 should be filed within 72 hours aft and Mental Hygiene. 27 Is marked other than "natural", or streumatic event, it is Medical Exert To Be Completed by F	(Specify only highest grade completed) (Give kind of work done during most of work) Elementary/Secondary (0·12) College (1-4or 5+)	ng	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
212 bd with a set that	5+ Independent Agent		Insurance
Maryland 2121 12 should be filed within 1 1 amarked other than "I treumatic event, I's Med		(First, Middle, Maid	den Sumame)
yla ould b Ment Ment Ment Ment Ment Ment Ment Ment		Regina S	
Mar 12 sh h and 7 Is m treum	19a. Informant's Name/Relationship (<i>Type, Print</i>) Margaret M. Coffey - Wife 7426 Berryleaf Drive,		
t and thealt sther	20a. Method of Disposition 20b. Place of Disposition (Name of		Location - City or Town, State
nor ages and of triffic y or o	1 → Burial 2 □ Cremation 3 □ Removal from State cemetery, crematory or other place)		
Baltimore, Permit. Pages 1 ar Department of Hea mportent: If them in y injury or other title.	Tout of modifier oundedly 1	J/UI/U/ pe Rinald	i Funeral Home, Inc.
Bal Permi Depa Impo			lver Spring, MD 2090
	23a. Part1. 50for the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac of shock, or heart failure. List only one cause on each line.		
Physician		VASCUI	
/Medical	resulting in death) Due to (or as a consequence of):		
Examiner	Sequentially list conditions.		1110
executed in and inal-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury	POROVED BY MEDICA	N M. 111-
xan xecut	that initiated events resulting in death) Last Due to (or as a consequence of):	NEOKA MEDICA	TEMM
	The state of the s	PAROVED	
687 tificate by phy as the	CERTIFIC		
O. Box ne death cer the attendir hed for use	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 5 Other (specify) 9 Unknown		23d. Date of delivery Month Day Year
cords, P.(w requires that if s been signed by should be detac	Part I/Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Quadriparesis due to two		co use contribute to the cause of death? 2 No 3 Probably 4 Horknown
ME ' I Vital Records, ysicien: The law requires t is certificate has been signe director, page 2 should be of	HEPERTENSION Cerebrovascular Accidents	24a. Was an autopsy performed	24b. Were autopsy findings available prior to completion of cause of death?
	25. Was case referred to medical examiner?		
- × s 5	1 ☐ Yes 2 ☐ Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: ☐ Jursing Hot	me 5 Residence	e 6 □Other (Specify)
On O	Natural 5 Pending (Month, Day Year) Injury Work?	28d. Describe how i	njury occurred
Division of Division of Division of Italian attending Part death. Set Director: Alter Italian by the funers Certification:	2 Accident investigation M 1 Yes 2 No		
or At in by in by	Suicide 4 Homicide 4 Homicide 4 Homicide 4 Suicide 5 Suicide 5 Suicide 6 Suicide 7 Suicide 7 Suicide 8 Suicide	City or Town, S	t and Number or Rural Route Number, tate)
Division of Division of To the Hospital or Attanding Phywithin 24 hours after death. To the Funeral Director: After the completely filled in by the funeral Medical Certification; The Medical Certification; The Complete of	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and manner stated.	and due to the caused at the time, date	e(s) and manner as stated. and place, and due to the cause(s)
o the vithin o the comple	29b. Signature and title of certifier / 29c. License number	29d.	Date signed (Month, Day, Year)
12/	Jasuer Lallian D28595	C	7/28/07
	30 Name and address of person who completed cause of death (Item 23a) (Type, Print) 1ASNEEM (AKHAMI, 2835 Sm17H QUE Sui	TE 203	BALTO MD 21279
State Registrar	31. Date filed (Month, Day, Year) OCT 0 2 2007		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** LEE ROY CRAWFORD SEPTEMBER 24, 2007 12:30 P M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 205 HERITAGE WAY CENTREVILLE QUEEN ANNE'S If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) JUNE 28, 1939 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign
Country) **Funeral** Days 1 XM 2 □ F 68 199-30-8759 OHIO Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 28a-f show notified at 1X Yes 2 No Director QUEEN ANNE'S MARYLAND CENTREVILLE 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code ms 23a or ? 205 HERITAGE WAY 21617 UNITED STATES Funeral items 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. an "natural", or iten Medical Examiner 1 XYes 2 No 1958-If Yes, Give 1961 Year or Dates: 1961 72 hours after 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 □ Yes 2 🛣 No WHITE Specify: ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) permit. Pages 1 and 2 should be filed w. Department of Health and Mental Hygien. Important: If item 27 is marked other tha any injury or other traumatte and injury or other traumatte and injury or other traumatte. the SUPERVISOR TELEPHONE COMPANY 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ROY G. CRAWFORD CLARA IRENE COX 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) KATHLEEN JOYCE CRAWFORD/WIFE 205 HERITAGE WAY, CENTREVILLE, MARYLAND 21617 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition SEPTEMBER 26 1 Burial 2 Cremation 3 ☐Removal from State CHESAPEAKECREMATION STEVENSVILLE, MARYLAND 5 ☐ Other (Specify) 2007 4 ☐ Donation FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 408 SOUTH LIBERTY STREET, CENTREVILLE, MD 21617 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cars on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Lectal Cancer **Physician** 5 years /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) P.0. ed by the a 9 Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 2 2 No 1 Yes 3 Probably 4 Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has 1∐ Yes director, 25. Was case referred to medical 26. Place of Death (Check only or Be examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ER/Outpatient 3□ DOA မှ 1 ☐ Inpatient this After this Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? To the Hospital or Attending Pl within 24 hours at er death. To the Funeral Director: After th completely filled in by the funeral 28b. Time of 28d. Describe how injury occurred Medical Certification: 1 Natural 2 ☐ Accident 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 052830 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) gate Road #300, Annapolis, Mis 21401 Date filed (Month, Day, Year), State Registrar

(Oropon)

33080 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 23:32 CARTER SEPT. 24 2007 ELIZABETH aka BETTY /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner WICOMICO SALISBURY COASTAL HOSPICE AT THE LAKE | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | NOV . 7 , 193 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🕅 F 76 Yrs. NEW JERSEY Director 217-30-7871 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State r than "natural", or Items 23a or 28a-f show the Modical Examinar must be notified at 1 ☐ Yes 2X No SELBYVILLE DELAWARE SUSSEX Direct 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 19975 28422 CYPRESS SWAMP ROAD USA Funerai 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Yes 2 ZNo If Yes, Give Year or Dates: hours after 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No þ WHITE 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) BOOKKEEPER RETAIL nd 2 should be filed value and Mental Hygie 27 is marked other traumatic event, in 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) McALLISTER **EDNA** 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any injury or other trau C. KENNETH CARTER/HUSBAND 28422 CYPRESS SWAMP ROAD, SELBYVILLE, DE. 19975 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State

4 ☐ Donation 5 ☒ Other (Specify) ENTOMBMENT GRANITE MEMORIALS | 10/1/07 BISHOPVILLE, MARYLAND 21. Signature of Funeral Service Licenses 22. Name and Address of Facility HASTINGS FUNERAL HOME, SELBYVILLE, DE. 19975 23a. Part 1. Enter the diserse, or complications that caused the shock, or heart failure. List only one cause on each line. eath. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) **Physician** ISSTru Due to (or as a consequence of): /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Physician/Medicai 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 plonths?

1 Yes 2 No
9 Unknown Day Month Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, δ 1 ☐ Yes 2000 3 Probably 4 Unknown 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No certificate 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes ≥ No 1 Impatient Certification: To 2 ER/Outpatient 3 DOA To the Funeral Director: After th completely filled in by the funeral 28a. D te of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Feath 28d. Describe how injury occurred 28b. Time of Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) after Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

#☐ Medical Examiner: On the basis of examination and/or investination in my opinion, death occurred at the To the Hospital within 24 hours a 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.) 29d. Date signed (Month, Day, Year) 29b. Signature and title of pertifier 02627 MA 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Box 1733 Salub, (weal) egistrar's Signature 31. Date filed (Month, Day, State 2007 Registrar

Baltimore,

P.0.

of Vital

Division

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) 4c. County of Death ne (If not institution, give street and number) or Location of Death 0 Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year) Months 1 M 2 XF 066-16-8080 86 2/24/1921 New York Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Willards Maryland Wicomico 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8281 New Hope Road 21874 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. l ∏Yes 2 **X** No f Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🛛 No Specify. Specify: white 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) electrical testing lab <u>Bookkeeper</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Anna Kearns Joseph Hatlak 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7 Reed St., Hauppaugh, NY 11799 Kenneth Heyman/son-in-law 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Buria! 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Pittsville Cemetery 9/28/07 Pittsville, MD 21. Signature of Funeral Service Licenses Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 Cerl 23a. Part1. Enter the disease, or complications that aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) - horu Due to (or as a consequence of): Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 23e. Did tobacco use contribute to the cause of death? 4 Unknown 1 🗌 Yes 2 No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy

Physician /Medical **Examiner**

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After this certification funeral director,

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Box 68760

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the Hospital or Attending Physician:

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permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at

Baltimore,

Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner

25. Was case referred to medical examiner? 2[No 1 ☐ Yes

27. Manner of Death

1 Natural 2 ☐ Accident

29a. Certifier

Hospital: 5 Pending investigation

1 Inpatient 2 ER/Outpatient 28b. Time of Injury

3□ DOA 28c. Injury at Work?

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28a. Date of Injury (Month, Day Year) 1 ☐ Yes 2 ☐ No

6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 ☐ Homicide

Decrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Decrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Decrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

26. Place of Death (Check only one)

and manner stated. 29b. Signature and title of certifier

28

2007

29c. License number

29d. Date signed (Month, Day, Year)

Date filed (Month, Day, Year) State SEP

30 Name

Registrar

State of Maryland / Department of Health and Mental Hygiens 33082 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day September 25, **Physician** Virginia Clark 2007 8:24 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner 3382 Pocomoke Road Salisbury Wicomico If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2 X F Yrs Director 220-32-1382 71 9/29/1935 Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Itam 27 is marked other then "natural", or Items 23a or 28a-1 show any Injury or other traumatic event, the Medical Examinary Process. 10a State 10h Count 10c. City. Town or Location 10d. Inside City Limits 1 Yes 2 No Director Maryland Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3382 Pocomoke Road 21804 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Marned 1 ☐ Yes 2 X No Specify: þ Spacify: white 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 City of Salisbury Secretary 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Clyde G. Livingston Eva Brown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Harry T. Clark, Jr/son 3382 Pocomoke Rd., Salisbury, MD 21804 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Parsons Cemetery 9/28/07 Salisbury, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22_Name and Address of Facility Home Professional Association Kitt R 501 Snow Hill Rd., Salisbury, MD 21804 RUNRA 23a. Part1. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) acuti myotardial Th_1 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of): ettending physicien and for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 4☐Pregnant at time of death 1 Yes 2 THO the 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed has been 24b. Were autopsy findings available prior to completion of cause of death? hertensin 24a. Was an autopsy performed? certificate 1 🗌 Yes 2 No 1 ☐ Yes 2 ☐ No After this certification To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death Check only one examiner? Other: 4 Nursing Home 5 Desidence 6 Other (Specify) Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending 1 Natural investigation 1 Yes 2 No 2 Accident Director: 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours after To the Funeral Dire 1 Desnitying Physician: To the best of my knowledge death occurred at the time date and place, and due to the date of and niam of at stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D15384 enuch, mo Dent. 26, 2007 ochey a completed cause of death (Item 23a) (Type, Print) SALISBURY RODNEY A. WENRICH 1346 PIVISIUN ST. 31. Date filed (Month, Day, Year) SEP 2 8 2007 🗗 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 0 7

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			For State Registrar		aryland		tificate of l			Reg. No.	01	33003	_
	Physic	ian	1. Decedent's Name (First, Middle Pauline Ma		÷11				2. Date of De Month	path Der 8, 2	novear 7	3. Time of Death	4
	/Med Exami		4a. Facility Name (If not institution	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 48 Valley Bottom Rd. Aberdeen						4c. County of Death Harford		2011	_
B	Funeral Director		5. Social Security Number 215–40–5083		00 (In yrs. Ia	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bi (Month, Di 3/24/1	rth ay, Year) 942	9. Birthp Cour Mary	place (State or Foreign ntry) Land	n
	Maryland f ehow	lor	Usual Residence of Decedent 10a. State 10b. County MD Hat	ford		Town or Lo					1	10d. Inside City Limits	
2 Le	death with the Maryland me 23a or 28a-f ehow ir must be notified at	Funeral Director	10e. Street and Number 48 Valley Bo				10f. Zip Code 21001			10g. Citizen of		ntry?	_
Jan (5-UUSO 72 hours after deat neturel, or iteme 3		11. Marital Status 1 □ Never Married 2 □ Mar 3 ☑ Widowed 4 □ Divorced	If Yes Give	,		Vas Decedent of H I Yes, specify Cuba □ Yes 2 14No	lispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or N Rican, etc.)	Bla	ce - Americack, White,	etc.	
777.	D 2 2 3	Completed by	15. Deceder (Specify only higher Elementary/Secondary (0-12)	nt's Education st grade completed) College (1-4or	5+)	(Give	DO NOT use retired	during most of work	ang	16b. Kind of I	Business/In feter		
andi	Maryland ZIZI d 2 should be filed within th and Mental Hygiene. 77 is marked other then traumatic event, tha Me	To Be Co	17. Father's Name (First, Middle, Frederick Ca			DOL V		18. Mother's Nam Virgie		a, Maiden Suma	те)		_
			19a. Informant's Name/Relations Debra R. Lauba			1206	Old Mour	and Number or Run ntain Rd.		ber, City or Town Joppa		21 085	
O .	0 90 = 5		20a. Method of Disposition 1 □ Burial 2√□€remation 4 □ Donation 5 □ Other (5			A. Fe	sition (Name of hatory or other place rris & Co	10/1		20c. Location West Ch	ester		_
Ċ	permit. Page Deportment important:		21. Signature of Funeral Service 23a. Part1. Enter the disease, lo	Ox (/ Nelex	bee		Aberdeen,	ss of Facility Cargo Fun Marylan	<u>a 2100</u>	1-3399	•	A	
•	Physician /Medical Examiner		shock, or heart failure. Lis Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	t only one cause on each I	ine. Luft a conseque uq	ence of):		ardid y di			664	Approximate Interval Between Onset and Death	
7	barbu, K	edicai Examiner	that initiated events resulting in death) Last	c. Due to (or as	a consequ	ience of):							_
4 4	D. BOX he death cert the ettendin	Completed by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Fetal	death 3	Ectopic pregnancy Other (specify)	y	(1.4		ate of deliv	very Day Year	
- M	rds, F. guires that the signed by ald be detacted.	d by Ph	Part II. Other significant condit	fense ontributing to death to	but not resu	ilting in the u	nderlying cause giv	ven in Part I.	1	_		the cause of death?	'n
ne	VITAI KECOTOS, sician: The law requires t certificate has been signe rector, page 2 should be o	Complete	/ /						l per	s an 24b opsy formed? 2 No	prior to co death?	opsy findings available ompletion of cause of	le
3:	VITAL P ilcian: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital:			Oth	26. Place of Dea		_			-
~		n: To	1 Yes 2 No 27. Manner of Death	28a. Date of Inj (Month, Da		28b. Time o	IL 3 DOA	4 🗆 Hursing n		idence 6 □0 how injury occi		(y)	
12		Certification:	3 ☐ Suicide 6 ☐ Could	not be 28e. Place of In		Injury me, farm, str		rk? Yes 2 □ No		(Street and Nun	nber or Rur	ral Route Number,	_
•	DIVISIO To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the to	dicai	(Check only 2 Medical one)	ng Physician: To the best Examiner: On the basis and manner s	of examinat tated.	ion and/or in	vestigation, in my o	opinion, death occu	rred at the time	e, date and place	and due	to the cause(s)	
	To th within To th	Me	29b. Signature and title of certifi	ar/		^	29c. Licens	se number		29d. Date sign	ned (Month	Day, Year)	
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	S Regis	tate trar	30. Name and little of certification. 30. Name and laddress of person. 31. Date filed (Month, Day, Year	5 2007 32. Regist	trar's Signa	S A	parli						

State of Maryland / Department of Health and Mental Hygiene 2 1 1 7

4b. City, Town, or Location of Death

WV

10d. Inside City Limits

Approximate Interval Between Onset and Death

Day

Year

AUTUIND

USA

1 Yes 2 □ No

1	-	For State Registrar				
1.	D	ecedent's	Name	(First,	Middle,	Last)

Bobbie Jack Calvert

4a. Facility Name (If not institution, give street and number)

Certificate of Death

3. Time of Death 2. Date of Death 2007 8:25 AM

4c. County of Death

Month

Physician
/Medical
Examiner

Funeral Director

Director

Funeral

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Completed

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Certification:

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Registrar

Dr. VASANT DAT

31. Date filed (Month, Day, Year)

death with the Maryland itsm 27 is marked other than "natural", or items 23a or 28a-f show other traumatic sysnt, the Madical Exeminer must be notified at Pages 1 and 2 should be filed within 72 hours after inent of Health and Mental Hygiene. Int: If itsm 27 Is marked other then "natural", or ite permit. Pages 1 Department of H Important: If its any injury or ot once.

Baltimore, Maryland 21215-0036

Physician /Medical **Examiner**

The law requires that the death certificate be executed as the burial-tran attending physicien use jo detached ate has been signed by page 2 should be detact filled in by the

Division of Vital Records, P.O. Box 68760,

Washington Hagerstown Autumn Assisted Living If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Mar 26, 1932 5. Social Security Number 7. Age (In yrs. last birthday) Days Hours 1 ☐ M 2 ☐ F 75 235-62-7907 Yrs. Usual Residence of Decedent 10a State 10c. City, Town or Location Fayetteville Franklin 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 17222 230 Ladnor Court 12. Was Decedent Ever in U.S. Armed Forces? 1 Xyes 2 □ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 Never Married 2 Married Specify: White 1 ☐ Yes 2X No 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Publisher Tech manual writer 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Theo Calvert Effie Cranford 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 230 Ladnor Court, Fayetteville, PA 17222 Alice Calvert 20b. Place of Disposition (Name of Cumber 1 and Walle & Crematorium 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Oct 6, 2007 Waynesboro, PA * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Grove-Rowersox Funeral Home 21. Signature of Funeral Service Licensee 50 S. Broad st., Waynesboro, PA 17268 James V. Daedersy Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition timo Duncan resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Judens of highly that initiated events Due to (or as a consequence of) resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 Probably 4 Honknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1 Yes 2 ₩O 25. Was case referred to medical examiner?

1 Yes 2 No 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 □ Yes 2 □ No investigation 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier att

24 hours

within 2 To the

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

5 2007 340

32 Registrar's Signature

D001801

HABERSTOWN MD 21740

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year Benedict Joseph Connor 10:45A 2007 Oc t 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Allegany FRostburg 17710 Old Dans Rock Road SW If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days 85 215-14-4218 27 1922Massachusetts Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. inside City Limits 1 ☐ Yes 2 🕅 No Allegany Frostburg MD 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 21532 United States 17710 Old Dans Rock Road SW Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11 Marital Status Black, White, etc. 1 Yes 2 No If Xes, Give 1943-45 Year or Dates: 1 Never Married 2 Married Specify: WHITE 1 ☐ Yes 2 No 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Bricklayer Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Eugune Marie Gallene Connor Alexander Paul Connor 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21775 Bancroft Court Ashburn VA David Connor 20147 Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cumberland Crematory10-9-2007 Cumberland, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Sowers Funeral Home, P.A. Sowers Funeral Hor Main Street Frostburg, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Man 21532 Approximate Interval Between Onset and Death Immediate Cause (Final Arteriosclerotic heart disease disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 4□Pregnant at time of death ☐Yes 2☐No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 1 ☐ Yes 3 ☐ Probably 4 ☐ Unknown

Physician /Medical Examiner

Physician

/Medical

Examiner

Director

Funeral

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Funeral

Director

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permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Ites any injury or other traumatic event, the Medical Examiner.

Baltimore, Maryland 21215-0036

with the Maryland

death Items ner mu

burial-tran physician The law requires that the death certificate be the as attending use ō detached signed by page 2 or Attending Physician: ector, After within 24 hours after death.

To the Funeral Director: A completely filled in by the fi

Division or Vital Records, P.O. Box 68760.

Exami Physician/Medical þ Completed Be P Medical Certification: in by t

				24a. Was an autopsy performed? 1∐ Yes 2 X No	24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No					
25. Was case referred to medical		26. Place of Death (Check only one)								
examiner? 1¥ Yes 2□ No	Hospital: 1 ☐ Inpatient 2 ☐	ospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)								
7. Manner of Death 1		28b. Time of Injury	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury	y occurred					
3 Suicide 6 Could not b 4 Homicide determined	28e. Place of injury - At h building, etc. (Speci	ome, farm, street, fa	28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a, Certifier (Check only one)	nysician: To the best of my known in the basis of examination and marker stated.	owledge, death occu ation and/or investiga	rred at the time, date and plac ation, in my opinion, death occ	e, and due to the cause(s) urred at the time, date and	and manner as stated. place, and due to the cause(s)					

29c. License number

09157

29d. Date signed (Month, Day, Year)

Oct

2007

State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD 124 3rd St. W. Cumberland, MD 21502 Snow,

5 2007 31. Date filed (Month

29b. Signature and title of certifier

2. Registrar's Signature

To the Hospital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** LOUISE CHESHIRE SEPTEMBER 16, 2007 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner CUMBERLAND ALLEGANY MEMORIAL HOSPITAL If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) JUNE 1,1913 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days ITALY 1 □ M 2**X** F 94 Director 234-62-2700 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State fshow an "natural", or items 23a or 28a-f show Medical Examiner must be notifiled at 1 ☐ Yes 2X No FORT ASHBY MINERAL Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U.S.A. WATER STREET 26719 permit. Pages 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s any Injury or other traumatic event, the Medical Examiner must by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: WHITE 3 N Widowed 4 Divorced Completed 16b, Kind of Business/Industry MINERAL COUNTY 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) BOARD OF EDUCATION COOK 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be JAMES BUFFER ROSE LENOTTI 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 472 LEON DRIVE, FORT ASHBY, WV DOROTHY MAGELITZ / EXECUTRIX 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State FORT ASHBY, WV FORT ASHBY CEMETERY 09/19/2007 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Ligens Name and Address of Facility UPCHURCH FUNERAL HOME, INC. 23a. Part1. Enter the disease, or comblications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. P.O. BOX 1260, FORT ASHBY, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CONGEST Physician /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examir Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 2 Fetal death Month Year Day in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☑ No 24a. Was an 1□ Yes 2 No Be 26. Place of Death Check onl one 25. Was case referred to medical examiner? Hospital: 1 Impatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this in by the funeral 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After (Month, Day Year) 1 Natural 5 Pending investigation 1 □ Yes 2 □ No 2 Accident after death Director; 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital within 24 hours at To the Funeral Completely filled in filled 1 🗂 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Rei. DmK nes

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ZAMAN, QAMAR U., M.D., 625 KENT AVENUE, SUITE 102, CUMBERLAND, MD 21502

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

32. Registrar's Signature 2007

Registrar

29c. License number

D23371

29d. Date signed (Month, Day, Year)

SEPT 17, 2007

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D0061652

11350 fembrooke G, walde

29d, Date signed (Month, Day, Year)

Examiner Box 68760, P.O. Records, Division of Vital the Hospital or Attending Physicien: hours after

physician and the burial-transit use as ò after death. filled in by within 24 hours a 0

Physician

/Medical

Examiner

10a. State

Funeral

Director

28a-f show

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permit. Pages 1 and 2 should be fit Department of Health and Mental Hy important: if item 27 is marked other eny injury or other traumeta.

Physician /Medical Director

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Certification:

Medical

(Check only one)

31. Date filed (Month

29b. Signature and title of

other treumatic event, the Mudical Examiner must be notified at

Maryland 21215-0036

Baltimore.

State Registrar

con pleted cause of death (Item 23a) (Type, Print)

L'UITE #304

32 Registrar's Signature

e Type of F	Tille ili Dia	ck illuelible ill	k. Elisu	I E All CO	ples Are	LE
State of	Maryland /	Department of	Health a	nd Menta	al Hygien	e

			For State Registrar		=	ertificate of			Reg. No. 2 ()	07	330	88
Г	Physici	an	1. Decedent's Name (First, Middle, Las Rollin Jerome					2. Date of De Month Sept.)07	3. Time of Dec 10:15 F	
E	/Medic		4a. Facility Name (If not institution, give			4h. City. Town. o	or Location of Death		4c. County		10:15 E	101
7	Examin	er	Heritage Harbour		Rehab.		polis			2 Aru	ndel	
	Funeral Director		5. Social Security Number 6. Social Security Number 215–38–4530		In yrs. last birthd	ay) If Under 1 Year	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da April 2	th ly, Year) 25,1940	9. Birthp	olace (State or Fo otry) Jinia	reign
	and		Usual Residence of Decedent 10a. State 10b. County	1	0c. City, Town o	r Location					I 0d. Inside City L	imits
	Maryl f sho	tor	MD Prince (George's	Bowi	le					1 XYes 2[□No
	r 28a	irec	10e. Street and Number			10f. Zip Code			10g. Citizen of	What Cou	ntry?	
	th wit 23a o 1st be	al D	5631 Park Drive			20715	5		USA			
21215-0036	filed within 72 hours after death with the Maryland Hygiene. uther than "natural"; or Items 23a or 28a-f show ent, the Medical Examiner must be notified at	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	12. Was Decedent Eve Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	er in U.S.	 Was Decedent of Hilf Yes, specify Cub 1 ☐ Yes 2 ☑ No 	Hispanic Origin? (Sp an, Mexican, Puerto Specify:	pecify Yes or No Rican, etc.)	Bla	ce - Americ ck, White, y: Whi		
Š	72 hou	ted	15. Decedent's Ed (Specify only highest gra	ucation	16a. De	ecedent's Usual Occup	pation	king	16b. Kind of B	usiness/In	dustry	
21	ithin 7 ne. nan "r	Completed by	Elementary/Secondary (0-12)	College (1-4or 5+)	Tit	e. DO NOT use retire	d)	Ning	Floor	ina		
2	led w hygier her th	Š	10 17. Father's Name (<i>First, Middle, Last</i>)			Carpenter	18. Mother's Nam	ne /Eiret Middle				
Maryland	d be fi	Be	Aubrey Dowell				Katheri			ne)		
Z	should nd Me mark imatic	ဥ	19a. Informant's Name/Relationship (7	vpe. Print)	19b. M	ailing Address (Street		-		State, Ziu	Code)	
<i>®</i>	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Importants if item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		James T. Dowell			1 Box 5 P-						
Baltimore,			20a. Method of Disposition 1º Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify	nemoval from State		isposition (Name of crematory or other pla ven Mem. Ga.1		Date 3, 007	20c. Location Frederi	-		
Balti	permit. Departm Importal any Inju		21. Signatur of Fu eral Service Licen			22. Name and Addre						
г	723		23a. Part1. Enter the disease, or comp shock, or heart failure. List only	nications that caused th	e death. Do not						Approximate Interval Between	en en
	Physician		Immediate Cause (Final disease or condition	Connection	Here	+ Fail.					Onset and Dea	th
	/Medical		resulting in death)	a. Lue (orasa o	consequence of):	1 mu	ne					
В	Examiner	_	Sequentially list conditions,	b. Carcho m	onsequence of							
	pe isit	nine	Sequentially list conditions, if any, leading to minimum action to the cause. Enter Underlying Cause (Disease or injury that initiated events	Little To (or area o								
	xecut and	Examiner	that initiated events resulting in death) Last									
68760,	e be e siciar	SalE		d								
89	tificate be executed ig physician and as the burial-transit	edical		u								
Division or Vital Records, P.O. Box	The law requires that the death cer ate has been signed by the attendin bage 2 should be detached for use	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome pf 1 □ Live birth 2 4 □ Pregnant at tir 9 □ Unknown	Fetal death	3 □Ectopic pregnand 5 □ Other (specify) _	у			ite of deliv	ery Day Yea	r
ds, P.	uires that i signed by id be deta	by	Part II. Other significant conditions of	ontributing to death but r	not resulting in th	e underlying cause giv	ven in Part I.	23e. Did t			he cause of deat	
3ecor	2 38 2	Completed						24a. Was	an 24b.	Were auto prior to co death?	opsy findings ava empletion of caus	ilable e of
<u></u>	ician: Th certificate rector, pag		25. Was case referred to medical					1□ Yes	2 No	1 ☐ Yes	211 No	
\equiv	Physician: r this certifica ral director, i	o Be	examiner?	Hospital: 1 ☐ Inpatient	2 ER/Outpa	itient 3 DOA Oth	26. Place of Dea		<i>one)</i> idence 6 □Otl	or (Coosi	6.)	
on or	Attending Physic death. ector: After this by the funeral dii		27. Manner of Death 1	28a. Date of Injury (Month, Day Y	28b. Tim	ne of 28c. Inju	ry at		how injury occur		<u> </u>	
Divisi	Hospital or Attended to the safter death Funeral Director: tely filled in by the	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of injury building, etc. (- At home, farm (Specify)	, street, factory, office			Street and Numi wn, State)	ber or Run	al Route Number	i
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Medical C	29a. Certifier 1 ☐ Certifying Ph (Check only one) 2 ☐ Medical Exan	ysician: To the best of r niner: On the basis of ex and manner state	xamination and/o	leath occurred at the tor investigation, in my	ime, date and place opinion, death occu	, and due to the irred at the time,	cause(s) and m	anner as s	stated. to the cause(s)	
	To the within 2 To the comple	Me	29b. Signature and title of certifier			29c. Licens			29d. Date signe		Day, Year)	
)			D 4/1/1/1			1038	958		10/1/2	2007		
2	110		30. Name and address of person who									
	6		Daljeet Sidhu,	M.D. 208	Crain H	wy. SW	Glen Bur	nie, MD	•			
	Sta Registi		31. Date filed (Month, Day, Year) OCT 0 2 2007	Janes D.	South							

DHMH 17 Rev 1/2001

			State of Maryland / Department of Health and N 1- State Senistrar Certificate of Death		ene 007	33089
			1. Decedent's Name (First, Middle, Last)	2. Date of Death		3. Time of Death
	Physici	100	Frank Benjamin Daniels	Month 9 3	Day Year 0 2007	1:14pM
	/Medic Examin		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death		4c. County of Deat	
	Examin	eı	Washington Adventist Hospital Takoma Park		Montgom	
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 6. The following of the security Number 1 Year If Under 24 Hrs. 75 Yrs. 75 Yr	(Month, Day,	11001	hplace (State or Foreign untry)
			Usual Residence of Decedent	11/15/	1931 p	·C
	ytand ytand		10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
	B-f-el	ctor	Md. Prince Georges Capitol Heights			1 ☐ Yes 2 No
	or 28)ire	10e. Street and Number 10f. Zip Code		g. Citizen of What Co	untry?
	ours after death with the Marylan rai', or Itema 23a or 28a-f ehow Examinar must be notified at	Funeral Director	625 Opus Avenue 20743		U.S.A.	
	r dez	rue	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Signed Forces) If Yes, specify Cuban, Mexican, Puerto	pecify Yes or No- o Rican, etc.)	14. Race - Ame Black, Whit	
36	or if	by Fi	1 □ Never Married 2 【X Married 1 □ Yes 2 【X No If Yes, Give 1 □ Yes 2 【X No Specify: Year or Dates:		Specify: b	lack
5-0036	72 hours after death with the Maryland "natural", or Itema 23a or 28a-f ahow idical Examinar must be notified at	ed b	3 Widowed 4 Divorced Year or Dates: 15. Decedent's Education 16a. Decedent's Usual Occupation	1	6b. Kind of Business/	Industry
5		Completed	(Specify only highest grade completed) (Give kind of work done during most of work life. DO NOT use retired)	king	ob. Tillia or basiliosa	
2121	within jiene. r then the Max	E O	Elementary/Secondary (0-12) College (1-4or 5+) 1 2 Government Employe	ee D	ept. of	Public Wks
Þ	othe	Be C	17. Father's Name (First, Middle, Last) 18. Mother's Name	ne (First, Middle, M	faiden Sumame)	
Maryland	2 should be filed within n and Mental Hygiene. Fie marked other then "raumatic event. The Mag	ToE	Marshall Daniels Sally	Rose	Berry	
Mai	d 2 sh th and 7 ie m traum	M 4	19a. Informant's Name/Relationship (Type, Print) Pauline Daniels/ wife 19b. Mailing Address (Street and Number or Ru 625 Opus Avenue, C		•	
	es 1 and of Health litem 27 rother t	3	20a Method of Disposition 20b. Place of Disposition (Name of		Oc. Location - City or	
Baltimore,			1 St Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Spepily) 1 St Burial 2 Cremation 3 Removal from State WashingtonNational 10	/02/07	Suitlan	d. Md.
ij	7 5 5 5	l	21. Signature Funeral Service Joynsee 22. Name and Address of Facility U			
B	Departiment in poor		411 Kennedy St.			
			23a. Parti. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line.	or respiratory arre	st,	Approximate Interval Between
	Physician			(cale	disease	Onset and Death
14	/Medical Examiner		Immediate Cause (Final disease or condition resulting in death) a. Athero Sclerotic Caydiova Due to (or as a consequence of): A Culle Reshirulary	PI		
14" 2	- Administr	_	Sequentially list conditions, if any leading to immediate b. A Cull Response to immediate Due to (or as a consequence of):	fails	Ne	
_	red	nin	cause. Enter Underlying Cause (Disease or injury			
5	sate be executed physician and the burial-transit	Examiner	that initiated events c. resulting in death) Last Due to (or as a consequence of):			
8760,	sate be shysicia the bur	dicai	d			
68	tifica ng ph as th	led				
Вох	leath certifica attending pl	an/h	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy		23d. Date of de	ivery Day Year
O. E	the at	Physician/Me	in the past 12 months? 1		Worth	Day (Gai
P.O.	that the de led by the a detached t		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tob	acco use contribute to	the cause of death?
Records,	9 9	d by		1 🗆 Ye	s 2 1 No 3 P	obably 4 Unknown
Ö	s been si should	Completed		24a. Was an		itopsy findings available
R	sician: The law s certificate has t lirector, page 2 s	lmo		autopsy perform	ned? death?	completion of cause of
	10	0	25. Was case referred to medical 26. Place of Dea	ath (Check only one		
>	Physician: r this certific ral director, i	To B	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 VEN Outpatient 3 DOA Other: 4 Nursing H	lome 5 Resider	nce 6 Other (Spe	cify)
	ft e		27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at 1 Natural 5 Pending (Month, Day Year) Injury Work?	28d. Describe hor		
Sio	Attending r death. ector: After by the fune	cati	2 Accident investigation M 1 Yes 2 No	200		
Division	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Certification:	4 Homicide determined determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	City or Town,	eet and Number or R , State)	urai Houte Number,
	spita hours ineral y filled		29a. Certifier 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place	, and due to the ca	use(s) and manner as	s stated.
	the Hein 24 the Fu	ledical	(Check only one) 2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurrence and manner stated.			
	To Toon	Σ	29b. Signature and title of certifier 29c. License number	1 /)	d. Date signed (Mont	n, Day, Year)
- 1	+		20 Name and address of access who completed areas of death (figure 2021) To a Color		7-30	T
	f		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) THUMINA KAHMPO SIVES FOR	the form	1000 209	03.
The state of	Sta	ite	31. Date filed (Month, Day, Year) OCT 0 2 2007 33 legistrar's Signature	1		
64	Registi	rar	UC UZ ZUUT MARIEN SE APRAGES			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Mong / 26/2007 Physician 11:10pm_M Paul B. Deinlein Sr. /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Anne Arundel 1604 Millersville Rd. Millersville 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number Date of Birth (Month, Day, Year) **Funeral** Months Days Hours MD. 1**X** M 2 ☐ F 212-36-3037 74 8/27/1933 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Millersville 1 ☐ Yes 2K No MD Anne Arundel Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21108 1604 Millersville Rd. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 15⊟Yes 2 □ No 51 – 55 If Yes, Give Year or Dates: 1 ☐ Never Married 3☐ Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2★ No Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Law Enforcement Police Officer 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John George Deinlein Myrtle Bennett ို 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1604 Millersville Rd. Millersville, MD 21108 19a. Informant's Name/Relationship (Type. Print) Wife Shirley Deinlein 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State Burian 2 ☐ Cremation 3 ☐ Removal from State Our Lady of the Fields 10/1/2007 Millersville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hardesty Funeral Home, P.A. 21. Signature of Funeral Syrvice Licensee 12 Ridgely Ave. Annapolis, MD 21401 22a. Part/ Enter the isease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart allure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cau e inal diseas or con librar resulting in de in Physician /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine the death certificate be executed and Due to (or as a consequence of): ed by the attending physician aldetached for use as the burial-Division or Vital Records, P.O. Box 68760 Physician/Medical as the IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 4□Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) ☐ Yes 2☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed Yes 2 certificate 1∏ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 1 ☐ Yes 2 No Residence 6 □Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA P this 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 27. Manper of Death 28c. Injury at Work? Certification: Attending Injury 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

in by the funeral after death. To the Hospital or A within 24 hours after or To the Funeral Direct

completely filled

OHI COTT State Registrar

0. Name and addre 31. Date filed (Month, Day, Year)

2 8 2007

and title of ce

29a. Certifier

29b. Signature

Medical

License number

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

)	Physic /Medi Exami	ca
	Funeral Director	3

		-	For State Registrar	State of Ma	ryland / Dep. <i>Ce</i>	artment of F ertificate of t			eg. No. 2007	33091
	Physicia	2.4	Decedent's Name (First, Middle, Last	•				2. Date of Deat Month SEPTEMBI	h Day Year ER 27 200	3. Time of Death
A.C.	/Medic	al .	JOHN WILLIAM 4a. Facility Name (If not institution, give	DAVIS		4b City Town o	r Location of Death		4c. County of Deat	
	Examin	er	FREDERICK MEMORI	· · · · · · · · · · · · · · · · · · ·	ĄL	FREDER			FREDERIC	
# 15 mm	Funeral Director		210-30-3284	ex 7. Age	(In yrs. last birthday 66 Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Nov. 25	Year) 9. Bird Co , 1940 Mar	thplace (State or Foreign ountry) yland
	/land ow at	1	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or L	ocation				10d. Inside City Limits
	Mary 1-f sho fied a	tor	Maryland Fre	ederick	Frede	rick				1 ∐Yes 2 ☑ No
	ith the	Director	10e. Street and Number			10f. Zip Code		10	0g. Citizen of What Co	ountry?
	s 23a		7732 Bridle Pat	h Circle	Cuprin II C 12	217		posity Voe or No.	USA 14. Race - Ame	erican Indian
5-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hyglene. Item 27 is marked other than "natural", or Items 23a or 28a-f show item 27 is marked other than "natural", or Items be notified at other traumatic event, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	Armed Forces? 1 Yes 2000 If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 No		Rican, etc.)	Black, Whit	e, etc.
5-0	"natul	Completed	15. Decedent's Ed (Specify only highest gra	ducation ade completed)	(Giv	edent's Usual Occup e kind of work done DO NOT use retired	during most of worl	king	16b. Kind of Business	/Industry
2121	filed within Hygiene. other than " ent, the Mec	дшс	Elementary/Secondary (0-12)	College (1-4or 5	+)	rity Cons	,		Private S	ecurity Co.
d 2	2 should be filed w s and Mental Hygie is marked other t raumatic event, th	Be	17. Father's Name (First, Middle, Last,					e (First, Middle, I		
ylar	should be tand Mental s marked or umatic eve	70 E	Clinton Eugene						abeth Cart	
Maryland	d 2 sh th and 7 is m traum		19a. Informant's Name/Relationship (Linda Sue Davis/V						; City or Town, State, . derick, MD	
	permit. Pages 1 and 2 Department of Health Important: If item 27 i any Injury or other tra once.		20a. Method of Disposition			oosition (Name of ematory or other pla			20c. Location - City or	
E			1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special		Norbeck M		1	_ '	Olney, Mar	yland
Baltimore,	permit. Page Department of Important: If any Injury or once.		21. Signature of Funeral Service Licer	nsee	F	22. Name and Addre	ss of Facility Collins	Funeral	Home Inc.	
	Q D = @ 0		23a Part 1 Eday the disease or com	plications that caused	the death. Do not ex	00 Univer	sity Blv	or respiratory arm	ilver_Spri	ng, MD 20901 Approximate
	Dhysisian		23a. Part1. En er the disease, or com shock, or heart failure. List only immediate Cause (Final	one cause on each lir	ie.	· A	4.	or roopiratory and		Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a. Due to (or as	cardiel a consequence of):	1276	rc 1 (3 h	\		5 min-tes
п	Examiner		Sequentially list conditions	b. diz	betes	mellit	· /)			
0	ed sit	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as	a consequence of):					
£	icate be executed physician and the burial-transit	Examiner	that initiated events resulting in death) Last	c Due to (or as	a consequence of):					
68760,	ificate be exe g physician ar as the burial-t	edical		d						
	a G	Medi	IF FEMALE:							
P.O. Box	w requires that the death certific been signed by the attending I should be detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. if yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal death 3	□Ectopic pregnanc □ Other (specify) _	у		23d. Date of de Month	Day Ye a r
	ss that gned b	by Pt	Part II. Other significant conditions	contributing to death b	ut not resulting in the	underlying cause giv	ven in Part I.		bacco use contribute t	
Division or Vital Records,	require een si nould t	ted						1 U Y	-	robabiy 4 □Unknown
3ec	e law has b	Completed						24a. Was a autops perfor	sv prior to	utopsy findings available completion of cause of
E	ificate or, pag		25. Was case referred to medical				26 Place of Dea		2 ☐N o 1 ☐ Ye	s 2,25No
>	yslcie is cert direct	To Be	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatie	ent 2 ER/Outpati	ent 3 DOA Oth	or.		ence 6 □Other (Spe	ecify)
n o	ng Ph ífter th ineral	L:uo	27. Manner of Death 1 Natural 5 Pending	28a. Date of Inju (Month, Da	ry 28b. Time y Year) injury	Wo		28d. Describe ho	ow injury occurred	
Sio	ttendl Jeath. Stor: A	catio	2 Accident investigatio 3 Suicide 6 Could not b	e 280 Place of init	ury - At home, farm, s		Yes 2 □ No	28f Location (S	treet and Number or F	Rural Route Number
DΪ	after of Direction by	Certification:	4 Homicide determined	building, et	c. (Specify)	street, lactory, office		City or Town	n, State)	idia/ riodic ridinsci,
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Medical C		hysician: To the best miner: On the basis o and manner st	f examination and/or	investigation, in my	opinion, death occu	irred at the time, o	date and place, and du	ue to the cause(s)
	_	Σ	29b. Signature and title of certifier		M 0	29c. Licen:	se number		29d. Date signed (Mor	
Ä.	10		Michael L						cpiemse	-24,2007
-			30. Name and address of person who Michael Lerner,	M.D. 400	West 7th		Frederick	, Maryla	and	
	Sta Regist		31. Date filed (Month, Day, Year) CCT 0 1 2		ar's Signature	well !				

State of Maryland / Department of Health and Mental Hygiene 33192 For State Registrar Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 09:10 AM 2007 Sept. 22, Geneva M. Davis /Medical 4b. City, Town, or Location of Death 4c. County of Death 4e. Fecility Name (If not institution, give street and number) Examiner Salisbury

If Under 1 Year | If Under 24 Hrs. |
Months | Days | Hours | Min. | Wicomico Peninsula Regional Medical Center Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** Months 1 □ M 2 🖾 F 74 12-03-1932 Marvland Director 220-26-8493 Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State or 28a-f ehow Pages 1 and 2 should be filed within 72 hours after death with the Marylan nent of Heatth and Mental Hygiene.
ant: if Item 27 is marked other then "naturel", or Items 23a or 28a-f ehow ury or other traumatic event, it a Medical Examiner must be notified. 1 ☐ Yes 2 ☐ No Director MD Wicomico Fruitland 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 21826 231 Sandcastle Boulevard Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2XXIIIo If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No white Specify. 3 Nidowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 8 Owner Sewing Center 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Osten Ray Wingate Mildred Thomas 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 231 Sandcastle Blvd. Fruitland, MD 21826 (Son) Robert O. Davis, Jr. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department o Important: If any injury or Wicomico Memorial Park 09-27-2007 Salisbury, Maryland * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Short Funeral Home
13 East Grove Street 21. Signature of Funeral Service Licenses 19940 Delmar, DE 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart-failure. List only offe cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final arrest **Physician** Cardiopulmenary day resulting in death) /Medical Due to (or as a consequence of): Examiner Clostridium monl Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Physician/Medical Examiner ng physician and as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) P.O. Box 68760. attending physician IF FEMALE 23c. If yes, outcome of pregnancy
1□Live birth 2□Fetel death
4□Pregnant at time of death esn 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? Month Day Po 5 Other (specify) ed by the a 9 Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 2 ☑No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy page perform 1 ☐ Yes 2 ☐ No this certificate 2 No 1 Yes or Attending Physician: 25. Was case referred to medical 26. Place of Death | Check only one Be examiner? Other: 4 \(\) Nursing Home \(5 \) Residence \(6 \) Other (Specify) 1 Yes 2 No 1 1 Inpatient ဂ္ဂ 2 ER/Outpatient 3 DOA p 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Medical Certification: After Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. 2 Accident investigation the within 24 hours after deat to the Funeral Director; 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by t 4 🗍 Homicide Hospital pelli 1 Exertifying Physician. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and tille of contrile DO06398 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Salisbury MP 145 E. MA Feel Ly. Carrell 32 egistrar's Signature 31. Date filed (Month Pay. State Registrar

07-07773

Tammara Lynn Edwards

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2007 33093

		For State				Certifi	icate of	Death					eg. No			3. Time of Death	
Physiciar Examin	1/	edistrar . Decedent's Name Tammar		e,Last) nn Edwa	rds							Date of Dea Month October 5	Day 5, 200	Yea	ar	0939 hrs	
		a. Facility Name (if		n, give street and	number)		4	b. City, Tov Seat Pl						c. County of Prince C	Seorge	e's	
Funeral	- 1	5. Social Security No	umber	6. Sex		(In yrs. last		If Under Months	1 Year Days	If Under Hours	24Hrs. Min.	8. Date of B			Foreig	thplace (State or in untry) NY	
Director	- 1	577-98-72 Usual Residence of		1 M 2 X F			Yrs.				l	07702	,			10d. Inside City Li	imits
v any		10a. State	10b. County		1		own or Locati	on								1 Yes 2 X	No
ne Maryland or 28a-f show any fred at once,	흱	MD 10e. Street and Nur		Arundel		Lau	rel	10f. Zip C	ode				10g. C	itizen of W	hat Cour	ntry?	
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death with the Maryland or items 23a or 28a-f shownest be notified at once.	Funeral	11. Marital Status 1 Never Marrie	od 2 N		Decedent E Forces?	ver in U.S.	13. Wa	s Deceden es, specify	t of Hisp Cuban,	anic Orig Mexican,	in? (Spe Puerto F	ecify Yes or N Rican, etc.)	NO-		te, etc.	Ican molan, bloom	
er death		3 Widowed		1 Ye vorced If Yes, Give		X: No		Yes 2						Specify:		ack	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	d by	15. Decedent's Ed	ducation (Sp	ecify only highest	rade com		16a. Deceder during m	nt's Usual C nost of work	occupations of the second seco	on (Give I DO NOT	kind of w use retir	ork done ed)	16b	. Kind of B	susiness/	/Industry	
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5-0036 led within 7 Hygiene. I other than	Com	12th 17. Father's Name		e, Last)			1101111		1	8.Mother	's Name	(First, Middle		en Sumam	ne)		
Z15 be file ental H arked	Be	Johnnie	Lee	Edwards			19b. Mailin	ig Address	(Stree	YVOI t and Nur	nne (Greene Rural Route N	Number	, City or To	wn, Stat	te, Zip Code)	
D 21 should and Me 7 is ma	10			on/Mother			6907	Craf	ton	Ln.		inton,	MD	. 207	35	or Town, State	
e, MD I and 2 sho Health and item 27 is		20a. Method of Dis	sposition	on 3 Remov		or cr	lace of Dispo ematory or o	ther place)				Date					
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Baltimore, permit. Pages I as Department of He Important: If ite		21. Signature of Fi	11	12 111			МY	irray	Fun	eral	Hom	e NW Wa	shi	ngtor	1. D	C 20011	
ysician	-	23a. Part I. Enter I	the difease,	or complications the se on each line.	nat caused	the death.	Do not enter	the mode	of dying,	such as	cardiac o	or respiratory	arrest,	shock, or	heart	Approximate In Between Ons- Death	et and
Medical Examiner		Immediate Cause	(Final disea	se a. He	roin I	ntoxic equence of	ation						_				
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P.O. s that the gned by e detach	1 2	3	minicant co	Tattons contribu	ang to doc							. 1	Yes			Probably 4 V Un	
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e law ite has l	1 4											1	Yes 2			Yes 2	No
/ital Roysician: This certifical		25. Was case re	ferred to me	dical Hospital:] 5D/D: to at	ant 3	26.Pla DOA	oe of Dea		sing Home	5 F	Residence	6 V C	Other: Scene	
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Fo the vithin 2 Fo the	Completely	one) 2		and m	basis of e anner state	examination ed.	and/or inves			ense num				29d. Date	signed	(Month, Day, Year))
		29b. Signature	and title of c	entitier	ŧ	mT	9			C.M.E.				Octobe	er 6, 20	007	
0		30. Name and a	address of p	erson who complet		of death (Ite	em 23a)							L			
LU		Ling Li, N	MD As	sistant Medica	l Exami	ner 11	1 Penn S		ltimor	e, MD 2	21201						
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		1	For State Registrar	State of N	Maryland		irtment o			ental Hygi	ene 2 0	07	33094	
			1. Decedent's Name (First, Middle, Las	it)						2. Date of Death Month	Dav	Year	3. Time of Death	
	Physicia /Medic	_	JOHN FRANKLIN E	'AMOUS						October		2007	11:03 PM	
	Examin		4a. Facility Name (If not institution, give	street and numbe	r)				ation of Death			ty of Death		
			3633 Mill Green				Stre		Under Dé Hee		Ho	arfor		
П	Funeral		5. Social Security Number 6. S	ex DXM 2□F	Age (In yrs. la 74	ast birthday) Yrs.	If Under 1 Y Months Da		Under 24 Hrs. ours Min.	8. Date of Birth (Month, Day, 11/26/1	Year)	Cou	place (State or Foreign ntry) y Land	
	Director	-	212-38-7088 Usual Residence of Decedent		74					11/20/1	JJ2	· iai	y Laria	
	ow I	1	10a. State 10b. County		10c. City	, Town or Lo	cation						10d. Inside City Limits	
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Mary	2 should be to and Mental his marked of reumetic eve		19a. Informant's Name/Relationship (-						<i>l Route Number,</i> Street,		n, State, Zi 1154	p Code)	
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			27a Part1 Enter the disgase, or com shock, or heart failure. List only	plications that caus	sed the deat	n. Do not ent	er the mode o	of dying, s	uch as cardiac o	r respiratory arre	est,		Approximate Interval Between	
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14	D #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or	as a consequ	uence of):								
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687	ficate g phys	Physician/Medical	d											
Rox	eath certific attending p	Z	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	me of pregna		∃Ectopic pregi	nancy				Date of deli	,	
ņ	death	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No		t at time of de		Other (speci		-		,	Month	Day Year	
O.	at the by th	hys	9 Unknown							one Diduct			the cause of death?	
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a	Physician: The la this certificate ha al director, page 3									1 ☐ Yes 2	.,	1 🗆 Yes	2□ No	
<u>=</u>	eiciar certil recto	Be	25. Was case referred to medical examiner? 1 Yes 2 7 No	Hospital:	ationt 2	EB/Outpation	nt_3 DOA	Other		n (Check only on me 5 . Reside		her (Snec	ofu)	
ō	Attending Physician: r death. sctor: After this certifice by the funeral director, i	7: To	27. Manner of Death	28a. Date of	Injury	28b. Time o		. Injury at Work?		28d. Describe ho				
<u>0</u>	nding I ath. r: After e funer	atio	1 Matural 5 ☐ Pending 2 ☐ Accident investigation		Day Year)	Injury	м		2 □ No					
Division of Vital Records,	or Attendent efter deat Director: in by the	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	200. Flace 01	Injury - At ho	ome, farm, st	reet, factory, o	office		28f. Location (St City or Town	reet and Nu n, State)	mber or Ru	ral Route Number,	
	itel or rs efte et Dir led in													
	To the Hospitel or Attending Ph within 24 hours efter death. To the Funerel Director: After th completely filled in by the funeral	edical	(Check only 2 Medical Exa	hysician: To the be miner: On the basi	s of examina	wledge, deat tion and/or in	th occurred at ivestigation, in	the time, my opini	date and place, on, death occurr	and due to the cared at the time, d	ause(s) and ate and plac	manner as e, and due	stated. to the cause(s)	
	thin 2 the othe	Med	one) 29b. Signature and title of certifier	and manne	stateo.		29c. L	_icense nu	umber	2	9d. Date sig	ned (Monti	h, Day, Year)	
	₹.¥ ₹. 8		Charly Valor	Christ			A I	DISS	16		act	iz	2007	
			30. Name and address of person who	completed cause	of death (Iten	n 23a) (Type			,					
	12		Charles Padgett wiD	560/2 La	ch Rave	n Bluel		10°Ce	MD 2123	9				
	Sta		31. Date filed (Month, Day, Year) 20		istrar's Signa		affect of							
	Regist	rar	0011020	S. S. S.		A								

		State of Manuard / Dep					
		State of Maryland / Department	artificate of Death		00005		
100		1. Decedent's Name (First, Middle, Last)		Reg. No. 2	3. Time of Death		
Physic /Medi Examii	cal	PAUL EDWARD FINNEYFROG 4a. Facility Name (If not institution, give street and number)	CK 4b. City, Town, or Location of Death	OCTOBER 8 2007			
Exami	iei	7025 RISON DRIVE	INDIAN HEAD	CHARLE			
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) $216-40-3626$ $\stackrel{1}{X}^{M}$ $^{2}\square$ F 64 Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Year) 11-3-1942 MA	thplace (State or Foreign ountry) RYLAND		
and w		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Lo	ocation		10d. Inside City Limits		
e Maryla 3a-f sho tifled at	ctor	MD. CHARLES	INDIAN HEAD		1 □Yes ¾□No		
with th	Funeral Director	10e. Street and Number 7025 RISON DRIVE	10f. Zip Code 20640	10g. Citizen of What C			
death ms 23 musi	nera		Was Decedent of Hispanic Origin? (Specif Yes, specify Cuban, Mexican, Puerto F		erican Indian,		
I E., With yith Ind. 2.12.13-0000 8.1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hyglene. If Health and Mental Hyglene. Item 27 is marked other than "natural", or items 23a or 23a-f show other traumatic event, the Medical Examiner must be notified at	þ	1 ☐ Never Married 2 🛛 Married 1 ☐ Yes 2 ☐ No	If Yes, specify Cuban, Mexican, Puerto F 1 ☐ Yes 2 【 No Specify:		vHITE		
in 72 hours af in 72 hours af in "natural", or Medical Exami	Completed	(Specify only highest grade completed) (Give	edent's Usual Occupation e kind of work done during most of workin DO NOT use retired)	g 16b. Kind of Business	i/industry		
filed within Hygiene. hther than '	Com		E PRESIDENT	CENTRUM (CONSTRUCTION		
should be filed and Mental Hygin marked other	To Be (17. Father's Name (First, Middle, Last) CALVIN LE ROY FJ. NEYFROCK		(First, Middle, Maiden Surname) MAE HOWES			
tand 2 sho 1 and 2 sho Health and N iem 27 is ma other trauma		19a. Informant's Name/Relationship (Type. Print) 19b. Maili 19b. Maili 702	ing Address (Street and Number or Rural 5 RISON DR. IND)	Route Number, City or Town, State, AN HEAD, MD 20	Zip Code) 0 6 4 0		
Datumore, permit. Pages 1 an Department of Heal Important: If Item 2 any Injury or other once.		20a. Method of Disposition 1 ☐ Gurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	osition (Name of Dematory or other place) MEM.GARDENS 10-	ate 20c. Location - City o -12-07 WALDORF	Town, State		
Dartillor permit. Pages Department of Important: If It any Injury or o		21. Signature of Funeral Service Licensee M00479	2 Name and Address of Eacility RAYMOND FUNERAL LA PLATA, MD. 200	SERVICE, P.A.			
		23a. Part1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.			Approximate Interval Between		
Physician /Medical		Immediate Cause (Final disease or condition resulting in death) a. Joynamus Particle Plants of the condition of the conditio	LMONARY FIBI	21515	Onset and Death		
Examiner	er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury					
te be executed ysician and e burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last C. Due to (or as a consequence of):		<u></u>			
ficate be exemple and physician a set the burial-	cal						
To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phys completely filled in by the funeral director, page 2 should be detached for use as the	Physician/Medi	1 Yes 2 No 4 Pregnant at time of death 5	□Ectopic pregnancy □ Other (specify)	23d. Date of do Month	*		
es that the igned by the detach		Part II. Other significant conditions contributing to death but not resulting in the u	underlying cause given in Part I.	23e. Did tobacco use contribute			
w require	eted	DI PERTEURAL			Probably 4 Unknown		
The lav	Completed by	S'LEEL APLIER			completion of cause of		
vital sician: T certificat irector, pa	o Be	25. Was case referred to medical examiner? 1 Yes 2 M No	26. Place of Death	1			
ig Phy ter this neral di	H	27. Manner of Death 28a. Date of Injury 28b. Time of	4 Nursing Hon	ne 5 Residence 6 Other (Sp 8d. Describe how injury occurred	ecify)		
Attending or detail. Attending or death. rector: After by the fune	satio	2 Accident investigation	M 1 Yes 2 No				
afferd afferd Direct	Certification:	4 Homicide determined 28e. Place of injury - At home, farm, st building, etc. (Specify)	treet, factory, office	8f. Location (Street and Number or F City or Town, State)	Rural Route Number,		
Hospita 24 hours Funeral etely filler	Medical C	29a. Certifier (Check only one) Check only one one one of the basis of examination and/or in and manner stated.	th occurred at the time, date and place, a nvestigation, in my opinion, death occurre	and due to the cause(s) and manner and at the time, date and place, and do	as stated. ue to the cause(s)		
To th within To th	Me	29b. Signature and title of certifier	29c. License number	29d. Date signed (Mor	nth, Day, Year)		
			012906	10/9/	07		
10		30. Name and address of person who completed cause of death (Item 23a) (Type	2070 ald Line C	who Woldens	and suns		
St	ate	31. Date filed (Month, Day, Year) 32. Begistrar's Signature	t s	, -, we worker,	7- 4 1 0000 0		
Regist	rar	OCT 1 6 2007 Been & A	mente				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) September 30 **Physician** Edward Arthur Faina /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Doctor's Community Hospital Prince George's Lanham If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Washington, DC 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours Min. 1 XM 2 □ F 577-64-1648 59 Aug 21, 1948 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10b. County 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 1 Yes 2 No New Carrollton MD Prince George's Directo 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Edward Baltimore, Maryland 21215-00360 in & 6616 Adrian Street 20784 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 GYes 2 No If Yes, Give Year or Dates: 1966-1969 1 Never Married 2 Married 1 ☐ Yes Ž No Specify: Completed by Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Taxi/Supply Elementary/Secondary (0-12) College (1-4or 5+) Cab Driver/Delivery Driver 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Louis Faina Lenora Delaney 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kitty Faina/wife 6616 Adrian Street, New Carrollton, MD 20784 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Metropolitan Crematory 10/2/07 Alexandria, Virginia 4 □ Donation _5 □ Other (Specify) 21. Signature of Financia Service License 22. Name and Address of Facility 4739 Baltimore Avenue Gasch's Funeral Home, PA Hyattsville, MD 20781 Vamuel, Mary 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 10 Cardial disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Due to (or as a consequence of) Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed for use as the burial-tran and Due to (or as a consequence of): or Vital Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 4☐Pregnant at time of death 5 ☐ Other (specify) been signed by the s 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page perform certificate 1 ☐ Yes or Attending Physician: 25. Was case referred to medical examiner? completely filled in by the funeral director, 26. Place of Death (Check only one) Medical Certification: To Be 1 ☐ Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural
2 Accident (Month, Day Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No death. after death 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation in my origin. 29a. Certifier (Check only Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Sig ature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

CR (5)

State Registrar 31. Date filed (Month, Day, Year)

eather

Dans 575 Mun Spreet Laurel, M. 26707

September D. Specker

and address of person who completed cause of death (Item 23a) (Type, Print)

MDO61131

9130107

Physician /Medical Examiner

nding physician

permit. Pages 1 Department of H Important: If ite any Injury or ot once.

Physician

/Medical

Examiner

Funeral

Director

ltems 23a or 28a-f show iner must be notifled at

WV

Director

Funeral

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Completed

Be

7

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or Items 23a or 28a-f show

the

Baltimore, Maryland 21215-0036

Be

Certification: To

Medical

29a. Certifier

Hospital or Attending Physiclan: The law requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760,

IF FEMALE: 23b. Was decedent pregint the past 12 month 1	dical Examine	Cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Part II. Other significant	ysician/Me	23b. Was decedent pregr in the past 12 month 1 ☐ Yes 2 ☐ No
	empleted by Ph	Part II. Other significant

0
23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal dea' 4□Pregnant at time of death 9□Unknown

			1	
3 ⊟Ectopic pregnancy 5 □ Other (specify)		23d. Date of de Month	elivery Day	Year
the underlying cause given in Part I.	23e. Did tobacc	co use contribute	to the cause	of death?

9 □ Unknown		
Part II. Other significant condition	ns contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco us
		1 ☐ Yes 2 🔀
		24a. Was an autopsy performed? 1 Yes 2 No

25. Was case referre	ed to medical								
examiner? 1 X Yes 2 N	lo	Hospital: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA							
27. Manner of Death 1 ☐ Natural 2 🎛 Accident	5 Pending investigation	- 4	28a. Date of Injury (Month, Day Ye Sep 22, 20		28b. Time of Injury 1:51p	M	28c.	Inju Wo	
3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could not be determined	9	28e. Place of injury building, etc. (5	- At he	ome, farm, street	, facto	ory, o	ffice	

26. Place of Death (Check only one)								
her: 4□ Nursing H	ome 5	Residence	6 □Other (Specify)					
rv at	28d. De	scribe how inju	rv occurred					

(Month, Day Year)	28b. Time of Injury 1:51p M	28c. Injury at Work? 1 ☐ Yes	2 💢 No	Motorcyclist who
Place of injury - At he building, etc. (Special Street	ome, farm, street, factory)	ory, office		28f. Location (Street and Number or City or Town, State) West

one)	and manner stated.	mination and/or investigation, in my opinion, death occurred at tr
29b. Signature ar	nd title of certifier	29c. License number
. /	01 2/1/1	A/A D 4 D37107

7th Street & Wilson Avenue, Frederick, MD Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. he time, date and place, and due to the cause(s)

> 29d. Date signed (Month, Day, Year) October 4, 2007

3 ☐ Probably 4 ☐ Unknown

struck vehicle

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Alan H. Rohrer, MD. DME, 15 West Seventh Street, Frederick, Maryland 21701-4501 31. Date filed (Month, Day, Year)

Registrar

24 hours after death Funeral Director:

within 24

3H-5+1

OCT 0 5 2007



		•	For State Registrar	State of	Marylan		artment of rtificate o				giene 0 0	17	33098	
10	MAR XX		1. Decedent's Name (First, Middle	e, Last)						2. Date of Dea Month		Yeer	3. Time of Death	
	. Physici /Medic		Sabrina	Gar	dner					Sept.	23, 2007		8:18 P.M	
	Examin	er	4a. Facility Name (If not institution	-	nber)		4b. City, Town				4c. County of Death Montgomery			
		.%-	Holy Cross Hos 5. Social Security Number		7. Age (In yrs.	last hirthday)	Silver			8. Date of Birtl			y place (State or Foreign	
	Funeral Director		577-08-6632	1 □ M 2 🖾 F	37	Yrs.	Months Day	s Hours	Min.	Feb. 20	(, Year)	Cou	hington,DC	
	D		Usual Residence of Decedent											
	show	<u>_</u>	10a. State 10b. County			y, Town or Lo							10d. Inside City Limits 1X Yes 2 ☐ No	
	the M	ectc	MD Frede 10e. Street and Number	rick	Fr	ederic	k 10f. Zip Code				10g. Citizen of W	hat Cou		
	with with	直	2089 Buell Dri	ve			2170				U.S.A		,	
	should be filed within 72 hours after death with the Maryland nd Mental Hyglene. I marked other than "netural", or itema 23a or 28a-f ahow umatic event, it a Madigal Examinar must be notified at	Funeral Director	11. Marital Status	12. Was Dece	dent Ever in U	.S. 13.	Was Decedent of If Yes, specify Co		Origin? (Spe	ecify Yes or No-	14. Race		can Indian,	
9	or its	Fur	1 ☐ Never Married 2 🔀 Marr	Armed For 1 ☐ Yes If Yes, Giv	2 🔀 No		ir res, speciny Ci 1 □ Yes 2🌠 N			Hican, etc.)	Specify:	, White, Bla	_	
21215-0036	ural',	d by	3 Widowed 4 Divorced	Year or Da	ites:				·,·					
15	n 72 l	Completed	(Specify only higher	t's Education st grade completed)		(Give	dent's Usual Oco kind of work dor DO NOT use reti	e durina m	ost of worki	ng	16b. Kind of Bus	b. Kind of Business/Industry		
77	with iene.	mo	Elementary/Secondary (0-12)	College (1	-4or 5+)	Accou	nt Repr	esent	ative		Govern	ment		
פַ	al Hyg other	BeC	17. Father's Name (First, Middle,	•				18. M o	ther's Name		Maiden Sumame	,)		
ylar	Ments Ments arked	10 E	Robert Lee Pen	dleton					ene Wa					
Maryland	alth and 27 is mu		19a. Informant's Name/Relations Reggie L. Gard		nd		Buell 1				or, City or Town, S 21702	itate, Zip	Code)	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Itema 23a or 28a-f show any injury or other traumatic event, Ita Medical Examination and be notified at ance.		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S		State	cemetery, crei	osition (Name of matory or other p oln Ceme		I	29,2007	20c. Location - C			
Balti	permit. Departm Importa any inju		21. Signature of Funeral Service	Licensee	renta.	22	2. Name and Add	ress of Fac	cility Ft	. Linco	ln F. H. twood, M		0722	
(e	* J _{S V}		23a. Part1. Enter the disease, or shock, or heart failure. List	complications that conly one cause on e	aused the deat ach line.	h. Do not ent	er the mode of o	ying, such	as cardiac d	or respiratory ar	rest,		Approximate Interval Between	
8	Physician		Immediate Cause (Final disease or condition	Sudde	en Card	iopulm	onary A	rest					Onset and Death Sudden	
7	/Medical Examiner		resulting in death)	Due to (or as a conseq	juence of):								
*		<u></u>	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. — Due to (or as a conseq	uence of):						_		
	uted I Insit	mlne	Cause (Disease or injury	<										
Ć.	exection and ital-tra	Examiner	that initiated events resulting in death) Last	C. Due to (or as a conseq	(uence of):								
8760,	death certificate be executed e attending physician and of for use as the burial-transit	Physician/Medical		d										
9	entifica ing ph e as tl	Med	IF FEMALE:											
Box	eath certific attending pl for use as t	lan	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnancy									23d. Date of delivery Month Day Year		
o.		ysic	1 □ Yes 2 🖾 No 9 □ Unknown	9□ Unkno		104(1) 3	Other (specify)							
٥.	law requires that the as been signed by th 2 should be detache		Part II. Other significant condition	ons contributing to de	eath but not res	ulting in the u	nderlying cause	given in Pa	rt I.	23e. Did to	obacco use contri	bute to f	the cause of death?	
rds	w requires been sign should be	ed by	Morbid Obesity	У						101	∕es 2KΩNo	3 ☐ Pro	bably 4 □Unknown	
of Vital Records,	aw requise been 2 should	Completed	Recent Laporo	scopic Gas	tric By	ypass S	Surgery			24a. Was		/ere auto	opsy findings available ompletion of cause of	
ž	0 - 0	E O	and a leak							perfo	rmed? de	eath?	2 No	
/ita	ician: Th certificate rector, pag	Be (25. Was case referred to medica examiner?						ace of Death	(Check only o	ne)			
<u></u>	Physician: this certific ral director.	မ	1 Yes 2 No		npatient 2		IL 3 DOA				ience 6 □Othe		fy)	
	Jing After fune	lon	27. Manner of Death 1 ⊠Natural 5 □ Pendir 2 □ Accident investi	19	h, Day Year)	28b. Time o Injury	V	juryat /ork? □Yes 2		28a. Describe r	now injury occurre	ia		
Division	l or Attending after death. Director: After I in by the fune	fica	3 ☐ Suicide 6 ☐ Could	not be	of Injury - At h	ome, farm, st	reet, factory, offic					or or Rur	al Route Number,	
<u>S</u>	al or A s after il Dire	Certification:	4 Homicide	buildir	ng, etc." (Special	fy)				City or Tov	vn, State)			
	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	edical (29a. Certifier 1 Certifyir (Check only one) 1 Medical	ng Physician: To the Examiner: On the ba	best of my kno asis of examina her stated.	owledge, deat ation and/or in	h occurred at the vestigation, in m	time, date y opinion, d	and place, death occurr	and due to the red at the time,	cause(s) and mar date and place, a	ner as s	stated. to the cause(s)	
	To the within 2 To the complet	Me	29b. Signature and title of certifie				29c. Lice	nse numbe	er er		29d. Date signed	(Month,	Dey, Year)	
)			1 M/k	ul\			D3:	L422			October	1, 1	2007	
11	(10)		30. Name and address of person S. McKenna, 9	who completed caus	e of death (Iter	m 23a) (Type,	Print)	Free	derick					
	()		S. McKenna, 9		egistrar's Sign			, , , , , , ,			-			
2	Sta Registi		OCT 0 2 2007	General)	o. do	et	>							

DHMH 17 Rev 1/2001

ORIGINAL

Physician /Medical Examiner

Funeral Director

	State Registrar			Ce	repartment of Health and Mental Hy Certificate of Death						Reg. No. 2007				09
	Decedent's Name (First, Middle, Last) Emmanuel Andreas Gerohristodoulos 2. Date of Death Month Day Year September 30, 2007											Year 07	3	i. Time o	of Death :15 an
	4a. Facility Name (If not institution, give	street and nui	mber)		4b. City, To	own, or	Location	of Death		4	4c. Count	y of Dea	th		
ı	7820 Carroll	Avenue				Tak	coma F	ark			Mo	ntgom	ery		
1	Social Security Number 6. S		7. Age (In yrs.	last birthday		Year Days	If Under	24 Hrs. Min.	8. Date of Bi (Month, D	rth av. Yea	ar)	9. Bir	thplace	e (State	or Foreig
	212-68-2877	M 2□F	80	Yrs.	INOTATIO	Dayo	riodio		March					Gree	ce
F	Usual Residence of Decedent		100 0	y, Town or L	o cotion								104	Incide (City Limit
	Maryland Montgome	ry	Toc. Cit	y, TOWITOTE		koma	Park								2 ⊠ N
	10e. Street and Number			10f. Zip C	Code				10g. (Citizen of	What Co	ountry?	?		
	7820 Carroll	Avenue				20	0912					U.S.A			
Ì	11. Marital Status	12, Was Dece Armed Fo	edent Ever in U	.S. 13	. Was Decede	ent of His	spanic O	rigin? (Sp	ecify Yes or N Bican, etc.)	0-		ce - Ame			
a combined by tamping of	1 ☐ Never Married 2 🔼 Married 3 ☐ Widowed 4 ☐ Divorced	2⊠ No ve ates:											ite		
	15. Decedent's Ed			16a. Dec	edent's Usual	Occupa	ation			16b.	Kind of E	Business	/Indus	try	
	(Specify only highest grad	College (1-4or 5+)	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Cabinet Maker								arpen	itrv		
	11 17. Father's Name (<i>First, Middle, Last</i>)			L	Japin			er's Name	e (First, Middle	e. Maio					
	,	011	h - d 1									•			
Andreas Emmanuel Gerohristodoulos Andronikki Gerohristodoulos													Zin Co		
19a. Informant's Name/Relationship (Type. Print) Andreas E. Gerohristodoulos - Son 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, S 5689 Caribbean Court, Haymarket, VA 20169											r, Glate,	Zip Co	iue)		
1	20a. Method of Disposition	doulos			isposition (Name of Date 20c. Location - City or Town, St								. State		
1 ⊠ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility											•			land	
Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Avenue. Silver Spring, M. 23a. Part1. Enter the dease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or help allure. List only one cause on each line.													Approximate Interval Between		
	shock, or her valure. List only one cause on each line. Immediate O Se (Final disease or o ndition resulting in death) Metastatic Adenocarcinoma of Rectum Due to (or as a consequence of):											tervar D	Death		
		a		nocarci									Öi	2.5	years
	resulting in death)	Due to		nocarci juence of):											
		b. Due to	(or as a consec	nocarcí juence of): juence of):									Ö		
	Sequentially list conditions, if any, leading to immediate cause. Enter undarrying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to b. Due to c. Due to d. 23c. If yes, ou	(or as a consection as a cons	nocarcí quence of): quence of): quence of):		Rect	um					ate of de	Oi	2.5	
	resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	a. Due to b. Due to c. Due to d	(or as a consection and at time of cown	nocarcí juence of): juence of): juence of): ancy al death 3 death 5	noma of	Rect	um		23e. Did	tobacc		fonth ntribute t	elivery Da	2.5	years Year
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	resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter undarrying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Part II. Other significant conditions of examiner? 1 ☐ Yes 2 ☑ No 27. Manner of Death	a. Due to b. Due to c. Due to d	(or as a consection as a conse	nocarcí juence of): juence of): ancy al death 3 death 5 sulting in the	B Ectopic pre Other (special control of the control	Rect	um 26. Placer: 4□ N y at k?	I.	23e. Did 1	tobacc] Yes s an opsy formed 2 \(\) \(\	No use couse	ntribute to a prior to death? 1 There (Spurred	Olivery Da do the corrobable complete security)	2.5	Year death? Junknow s availab cause of
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Registrar DHMH 17 Rev 1/2001

State

Thomas A. Bensinger, M.D.,

2007

31. Date filed (Month, Day, Year) OCT 0 2

32. Degistrar's Signature

7525 Greenway Center Drive, Greenbelt, Maryland 20770

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hydien 2 0 0 7

		1	For State Registrar		Maryland /		artment tificate				Re	g. No.	007	33100	
	Physicia	an	Decedent's Name (First, Middle		tha GOLD)					Date of Death Month Ptembe		, 2 [°] 007	3. Time of Death 6:30 P M	
	/Medic Examin		4a. Facility Name (If not institution, 14620 Deerhurst	-	r)		-	y, Town, or Location of Death					4c. County of Death Montgomery		
	Funeral Director		5. Social Security Number 579–14–0376		Age (In yrs. last i	birthday) Yrs.	If Under		If Under:	~	Date of Birth (Month, Day (CN 28	Year) 19	9. Birth	hplace (State or Foreign untry) Md N y	
	Maryland ahow Ified al	tor	Usual Residence of Decedent 10a. State 10b. County Maryland Monto	jomery	10c. City, To		cation Spri	ng					10d. Inside City Limits		
	with the	Dlrec	10e. Street and Number 14620 Deerhurst	Court			10f. Zip		906			•	n of What Co ced Sta	_ '	
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene Important: If item 27 Is marked other than "natural", or items 23a or 28a-f ahow important: If item 27 Is marked other than "natural", or items 23a or 28a-f ahow pray injury or other traumatic evant, the Medical Examiner must be notified at ances.	Completed by Funeral Director	11. Marital Status 1 Never Married 2 Marria 3 Never Married 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces?			Was Decedent of Hispanic Origin? (Specify Yes or Nif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:					14	. Race - Ame Black, White	rican Indian,	
	vithin 72 hou ne. han "natura n Medical E	mpleted	15. Decedent (Specify only highes Elementary/Secondary (0-12)	t grade completed)	College (1-4or 5+) (Give kind of life. DO NO					t of working		of Business/	Industry		
land 21	ld be filed w ental Hygiel ked other ti ic evant, In	To Be Co	12 Homemaker Own Home 17. Father's Name (First, Middle, Last) Sidney Migdal 18. Mother's Name (First, Middle, Maiden Sumame) Jennie Moskowitz												
Mary	12 shou h and M 7 la mar traumat	1 3	19a. Informant's Name/Relations: Jerome Gold, So		3	19b. Mailir 700 N	ng Address	(Street a	Lane	er or Rural R	oute Number,	City or 7	Town, State, 2 332	Zip Code)	
more, l	ages 1 and ant of Health it: If itam 27 y or other tr		20a. Method of Disposition 1	3 □Removal from Sta	20b. Place ceme Mt.	e of Dispo etery, crei Lebai	osition (Nam matory or or non Ce	ne of ther place emete	ery 1	Date 0/03/0			ohi, M		
Baltii	permit. P Departm Importal any inju		21. Signature of Fune 11 to have		5	12	54 Car	rrol	1 St.	, NW,	neral H Washir	ngtor	i, DC	20012	
	Physician /Medical	9)	23a. Part1. Enter the disease, or shock, or heart failure. List immediate Cause (Final disease or condition resulting in death)	Conge	stive He	eart			g, such as	cardiac or re	espiratory arre	est,		Approximate Interval Between Onset and Death 5 Years	
68760,	ate be executed hysician and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Arter Due to (or	Due to (or as a consequence of): Arteriosclerotic Heart Disease Due to (or as a consequence of): C. Due to (or as a consequence of): d.								26 Years		
.O. Box 6	at the death certific by the attending patached for use as t	Physician/Med	IFFEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 2 No 9 Unknown 2 Fetal death 3 Ectopic pregnant at time of death 5 Other (specification of the companion of the compan									23	23d. Date of delivery Month Day Year		
<u>α</u>	signed d be de	by	Part II. Other significant conditi	ons contributing to deat	h but not resultir	ng in the u	underlying c	ause give	en in Part	l. 	23e. Did tobacco use contribute to the cause of death? 1 Yes 2 X No 3 Probably 4 Unknow				
al Records,		Completed								(D. W.	24a. Was a autops perform	ned? 2 X No			
ion of Vital	ing Phys I. After this funeral di	atlon: To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pendir investi	VOutpatie Bb. Time of Injury		28c. Injury Work	er: 4□N ∕at	ursing Home 28	Death Check onleance 6 ☐ Other (Specify) 28d. Describe how injury occurred						
Division	i Zir	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	ained 286. Flace U	Injury - At home , etc. <i>(Specify)</i>	e, farm, si	treet, factor	y, office		28	f. Location (St City or Town		Number or R	lural Route Number,	
	To tha Hospital within 24 hours a To tha Funaral Completely filled	Medical (29a. Certifier 1. Certifyii (Check only 2 ☐ Medical	ng Physician: To the b Examiner: On the bas and manne	is of examination	edge, dea n and/or ir	th occurred nvestigation	at the time, in my of	ne, date a pinion, de	nd place, and ath occurred	d due to the c at the time, d	ause(s) a late and p	and manner a place, and du	s stated. e to the cause(s)	
)	To tha within 2 To tha complet	Me	29b. Signature and title of centile		last	X	296		e number 01212	21	2		-	th, Day, Year) 1, 2007	
	10		30. Name and address of person 3929 Ferrara	who completed cause Drive, Whea	of death (Item 23 ton, MD	^{3a) (Type} 20	906	Georg	ge F.	Seng	stack,	M.D	•		
	St Regist	ate rar	31. Date filed (Month, Day, Year	2007	gistrar's Signatur	е	ceels)	9							

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			1 - For State Registrar	State of Maryland		artment of H tificate of L		nd Mental Hy	giene Reg. No:		33103			
	• Physici	an	1. Decedent's Name (First, Middle, Last)					2. Date of De Month	ath Day	Year	3. Time of Death			
	/Medic	al	William Gilmore Gr			4b. City, Town, or		10	1 2007 2:30 A M					
	Examin	er	4a. Facility Name (If not institution, give s Julia Manor	treet and number)				Death		Washington				
196	Funeral		5. Social Security Number 6. Sex		ast birthday)	Hagersto	If Under 24	Hrs. 8. Date of Bi	th		hplace (State or Foreign buntry)	7		
Þ	Director		404-44-1135	M 2□F 74	Yrs.	Months Days	Hours	2/22/1			hio			
	and ow if		Usual Residence of Decedent 10a. State 10b. County	10c. City	, Town or Lo	cation					10d. Inside City Limits	_		
	Mary Ified s	to	Maryland Washingt	on Hage	rstown						1 ☐ Yes 2 🔀 No			
	th the	irec	10e. Street and Number	on mage	LSCOWII	10f. Zip Code			10g. Citi	zen of What Co	ountry?	Т		
	ath wi	Funeral Director	17960 Garden Lane			217 40				USA				
	ler de Items nerr	nue	11. Marital Status 1 Never Married 2 Married	12. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2X No	S. 13. \	Was Decedent of Hi f Yes, specify Cuba	ispanic Origir ın, Mexican, f	n? (Specify Yes or No Puerto Rican, etc.))-	14. Race - Ame Black, Whit				
920	urs af	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		I□Yes 2XINo	Specify:			Specify: W	hite			
5-0036	72 hours atter death with the Maryland natural', or Items 23s or 28s-1 show Steal Evanified nutt be molified at	Completed	15. Decedent's Educ (Specify only highest grade		16a. Deced	lent's Usual Occupa kind of work done of DO NOT use retired	ation during most o	of working	16b. Ki	nd of Business	Industry			
21	filed within Hygiene. ther than "	щ	Elementary/Secondary (0-12)	College (1-4or 5+)		00 NOT use retired t Manager		· ·	Ra	nking				
d 21	filed v Hygie ther t	ပို	17. Father's Name (First, Middle, Last)		Crear	t Hallagel		s Name (First, Middle				-		
an	ild be lental ked o	To Be	Donald E. Gregg				Maria							
Maryland	12 should be filed within h and Mental Hygiene. 7 is marked other than "Iraumatic event, the Me.		19a. Informant's Name/Relationship (Ty	oe, Print)	19b. Mailir	g Address (Street		or Rural Route Numb	er, City o	r Town, State,	Zip Code)			
	and 2 ealth m 27 I	. 3	Daniel Gregg/Son	lea p	_	_	Ct. Ha	agerstown,						
Baltimore,	Pages 1 nent of H int: If ite		20a. Method of Disposition 1 ☐ Burial 2X☐ Cremation 3 ☐ R	emoval from State	əmetery, crer	sition (Name of natory or other place	e) 1 (Date 0 / 3 / 2007		cation - City or				
Ħ			* 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Ligense			g Cremeto	ss of Facility	0/3/2007	Smit.	hsburg,	MD	-		
B	permit. Departr Importa any inji		21. Signature of Funeral Service Libensee 22. Name and Address of Facility Rest Haven Funeral Chapel 1601 Pennsylvania Ave. Hagerstown, MD 21742											
	02.54	Siller	23a. Part1. Enter the disease, or compli shock, or heart failure. List only or	cations that caused the death							Approximate Interval Between			
	Physician		Immediate Cause (Final disease or condition	Sarcom	a d	eft hea					Onset and Death			
	/Medical Examiner		resulting in death)	Due to (or as a consequ		001					<u></u>			
	TENT	e.	Sequentially list conditions,	Due to (or as a consequ	ience of):	levis					17	-		
	outed ansit	Examin	Sequentially list conditions, it any, sacing to immodiate cause. Enter Underlying Cause (Disease or injury that initiated events											
Ó,	cate be executed oblysician and the burial-transit	Exa	resulting in death) Last	Due to (or as a consequ	ience of):									
8760,	The law requires that the death certificate be executed the bas been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physiclan/Medical				_								
Box 6	eath certilic attending p	/Me	IF FEMALE: 23b. Was decedent pregnant			23d. Date of de	livery							
	death e atte	icla	in the past 12 months?			Month Day Year		1						
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	ires tha signed d be det	by	Part II. Other significant conditions cor	itributing to death but not rest	alting in the u	nderlying cause givi	en in Part I.		Yes 2		the cause of death?			
ö	w requir been si should	etec						24a. Was	-		utopsy findings available	_		
Records,	he lav e has	Completed						auto	psy prmed/?	prior to death?	completion of cause of			
Vital		Be Co	25. Was case referred to medical				26. Place o	1 ☐ Yes of Death (Check only	2)Z No one)	I Tes	2 □ No	-		
of V	Physician: The I this certilicate har al director, page	ToE	examiner? 1 ☐ Yes 2 PNo	lospital: 1 Inpatient 2	ER/Outpatier	t 3 DOA Othe	er: 4 Nurs	sing Home 5 Res	idence	6 □Other (Spe	cify)			
o no	ding Pi h. After t funera		27, Manner of Death 1 Sent Sent Sent Sent Sent Sent Sent Sent	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	Worl	k?	28d. Describe	how injur	y occurred				
Division	Attending r death. ector: After by the fune	licat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - At ho	me farm str		Yes 2 □ No		Street an	d Number or R	ural Route Number,	-		
Di√	alter deat alter deat Director: d in by the	Certification;	4 Homicide determined	building, etc. (Specify	()	oet, ractory, office		City or To						
	To the Hospital or Attending within 24 hours alter death. To the Funeral Director: After completely Jilled in by the funer	edical C		sician: To the best of my knowner: On the basis of examinat and manner stated.								_		
	within To th comp	Me	29b. Signature and title of certifier			29c. License	e number		29d. Dat	e signed (Mon	h, Day, Year)			
) Cua				232		10-	01-2	907			
, ki	l (30. Name and address of person who co					-						
15F	Sta	ato.	Opal Medical Ct. 31. Date filed (Month_Day, Year)	32. Registrar's Signa		stown, MD	21740)						
	Registi		OCT 0 3 20	007		mile								

			1 _ State	Maryland		irtment of H tificate of I		•	giene Reg. No. 2 N (77 22101
1			Registrar 1. Decedent's Name (First, Middle, Last)	2. Date of De	3. Time of Death					
-	Physici /Medic		ROBERT LEE GRAMS SR.					Month SEPTEME		ear 007 10 33 P ^M
	Examin	er	4a. Facility Name (If not institution, give street and numb	er)		4b. City, Town, or	Location of Death	1	4c. County of	Death
18	· · · · · · · · · · · · · · · · · · ·			SPITAL Age (In yrs. Ia	et hiethdou)	FREDE	RICK If Under 24 Hrs.	8. Date of Bir		ERICK
П	Funeral Director		220-18-0473	79	Yrs.	Months Days	Hours Min.	(Month, Da	y, Year)	Birthplace (State or Foreign Country) Maryland
a.E.	D		Usual Residence of Decedent					NOV. I	39 1721	
	arylar show	r	10a. State 10b. County	10c. City,	, Town or Loc	cation				10d. Inside City Limits 1 ☐ Yes 2X No
	the M 28a-f notifie	ecto	Maryland Frederick 10e. Street and Number	F	reder	Lck 10f. Zip Code			10g. Citizen of Wha	
	3a or	ΙΩ	1820 Latham Drive			217	02		United S	
	death	Funeral Director	11. Marital Status 12. Was Deceder Armed Force	ent Ever in U.S	3. 13. V	Vas Decedent of Hi Yes, specify Cuba		pecify Yes or No		American Indian,
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importants: if item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	by Fu	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 If Yes, Give Year or Date	No No		Yes AND	Specify:	o nican, etc.)	Specify:	White, etc. White
21215-0036	72 hou natura ical E	Completed	15. Decedent's Education	Ī	16a. Deced	ent's Usual Occup	ation	lein a	16b. Kind of Busin	ness/Industry
215	ithin 7 ne. nan "r	nple	(Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired)							
	led w fygier her th	ပ္ပ	17. Father's Name (First, Middle, Last)			Brakem		o (First Stindelle	Railr Maiden Surname)	oad
Maryland	d be fi) Be	Leroy Grams					isy Har	,	
	shoul nd Me mark	2	19a. Informant's Name/Relationship (Type. Print)		19b. Mailin	g Address (Street a			er, City or Town, Sta	ate, Zip Code)
	and 2 salth a 27 is		Robert Grams Jr. / Son		1817	7 Point o	f Rocks	Road, K	noxville.	MD 21758
ore	of He of He if item or oth		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from St		ace of Dispos	sition (Name of natory or other plac	i	Date	20c. Location - Cit	
ij	t. Pag tment tant:		4 ☐ Donation 5 ☐ Other (Specify)	Bro		Lle Cemet				ille, Maryland
Baltimore,	permit Depar Impor any In		21. Signatury of Funeral Service Licensee	Let		Name and Addres			r Funeral swick, MD	
			23a Part . Enter the disease, or complications that of shock, or heart failure. List only one cause on each	sed the death. h line.	. Do not ente	er the mode of dyin	g, such as cardiad	or respiratory a	rrest,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death)	2001	2					Onset and Death
	/Medical Examiner		Due to 6	as a conseque	ence of):	Louist	2			
	*	Jer	Sequentially list conditions, it any, legan 5 to immediate	as a consequir	wnow ut):	Jewes				
	cuted nd ransit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events C	2,950	Gerai	ie and	enasce	elar a	leseaso	,
90,	icate be executed physician and s the burial-transit	Ĕ	But to for an a control destroy.							
68760,	physic physic the b	edical	d							
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Ö.	uires that the death certificate be executed signed by the attending physician and be detached for use as the burial-transit	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	Month						
P.0.	that the		Part II. Other significant conditions contributing to deal	th but not resul	Iting in the un	derlying cause give	en in Part I.	23e. Did t	obacco use contribu	ute to the cause of death?
Division or Vital Records,	The law requires that the death certifite has been signed by the attending page 2 should be detached for use a	ed by	Diabetes, periphera	Pyras	ada	n dese	ese,	10	res 21 No 31	☐ Probably 4 ☐Unknown
3ec	e law r has be	Completed	hyperlipedernia	pol	Non	1 5/20	ske	24a. Was	osy prio	re autopsy findings available or to completion of cause of
a	sician; The law certificate has b irector, page 2 s		77 M					1□ Yes	2√No 1□	ath? ÌYes 2□ No
<u>=</u>	ysicia is certi directo	o Be	25. Was case referred to medical examiner? 1 \(\subseteq \text{Yes} \) 25 \(\subseteq \text{No} \) Hospital: 1 \(\subseteq \text{Inp} \)	natient 2□F	R/Outpatient	3D DOA Othe	26. Place of Dea		<i>ne)</i> dence 6 □Other	(Specific)
יסר	ding Physician; The n. After this certificate h funeral director, page	n: To	27. Manner of Teath 28a. Date of		28b. Time of Injury	28c. Injury Work			now injury occurred	"Ѕреспу)
Sior	tendir sath. or: Af the fur	atio	2 Accident investigation		,,		Yes 2 □ No			
<u> </u>	al or Atteno after death il Director: id in by the f	Certification:	determined 286. Place of	finjury - At hon , etc. (Specify)	me, farm, stre	eet, factory, office		28f. Location (S City or To		or Rural Route Number,
	To the Hospital or Attending Physician: within 24 hours after deals as after deals. To the Funeral Director: After this certification in the funeral director, completely filled in by the funeral director,	edical (29a. Certifier (Check only one) 1.5 Certifying Physician: To the base and manne	is of examinati	vledge, death ion and/or inv	occurred at the tin restigation, in my o	ne, date and place pinion, death occu	e, and due to the arred at the time,	cause(s) and mann date and place, and	er as stated. If due to the cause(s)
	To th within To th compl	Me	29b. Signature and title of certifier	21	/	29c. License	e number		29d. Date signed (I	Month, Day, Year)
			Who High de	Alle	Lun) かき	3518	3	Septem	her 27,2007
•	5		30. Name and address of person who completed cause	of death (Item :	23a) (Type, F	Print)	ath 1	1 1	1-0.	rick, MD
	Sta	t o	31. Date filed (Month, Day, Year) 32 Reg	gistrar's Signa	SUG Te	yes!	70-18	reel,	rreae,	rick, MI)
	ાં Registr		OCT 0 2 2007	we D	17					•

			1 - For State Registrar			laryland		rtment of F	Death		Reg. No.	007	33105		
	Physicia /Medic		1. Decedent's Name (Fin Dolore			٧.		Huguley		2. Date of De September		7 Year	3. Time of Death 6:10 A M		
	Examin		4a. Facility Name (If not)		4b. City, Town, o Berlin	r Location of Death	1	4c. Coun	ty of Death Worce	oton		
	Funeral Director		Atlantic Gen 5. Social Security Number 472-18-0395	er 6. S		ge (In yrs. Ia: 85	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da March 2	th 19, 1922		olace (State or Foreign olacy) nesota		
	yland how		Usual Residence of Dec 10a. State 10t	b. County		10c. City,	Town or Lo	eation					10d. Inside City Limits		
	Ba-f •	Funeral Director		St. Mary'	S	Cal	ifornia						1 ☐ Yes 2 📉No		
	death with the Maryla eme 23e or 28a-f ehor	Dire	10e. Street and Number		. l. D. l			10f. Zip Code			10g. Citizen o	f What Cou	ntry?		
		erai	24309 N. Pat	uxant be	12. Was Deceden	t Ever in U.S	. 13. V	20619		pecify Yes or No	USA 14. R	ace - Ameri	can Indian,		
21215-0036	ours after d rel', or iten Examiner	by	1 Never Married		ned 1 □Yes 2 ĀNo If Yes, Give Year or Dates:			Yes, specify Cuba	dispanic Origin? (S) an, Mexican, Puerti Specify:		Black, White, etc. Specify: White				
5-0	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other then "nature!", or iteme 23e or 28a-f ehow aumatic event, the Madical Examiner must be notified at	etec	15. (Specify o	Decedent's Ed	ducation ade completed)		16a. Deced (Give	ent's Usual Occup	pation during most of world)	kıng	16b. Kind ol	Business/in	dustry		
121		Completed	Elementary/Secondar	y (0-12)	College (1-4or	5+)		outer Progr			Federal	Cover	nment		
d 2	be filed ital Hygi of other event, I	Be Co	17. Father's Name (First	t, Middle, Last)				11081	18. Mother's Nan	ne (First, Middle			I MIRCITO		
/lan	uld be Menta mrked atto ev	ToB	Francis	Warren	Noles				Anne	Veronica	Tuohy				
Maryland	9 € N ₽		19a Informant's Name/ Andrea M. Mil						and Number or Ru Lve Oxon Hi		Number, City or Town, State, Zip Code) rvland 20745				
	s 1 and 2 of Heelth Item 27 i	0	20a. Method of Dispositi		3D 1/ 0) 1	20b. Pla		sition (Name of natory or other place		Date	20c. Location	n - City or T	own, State		
, E	Pages Iment of I tant: If It		4 □Donation 5 □	Other (Specif		9 _	of Hea	wen Cemete	ery 10/03,				Maryland		
Baltimore,	permit. Pages 1 and Department of Heel Important: If Item 2 eny Injury or other Once.		21. Signature of Funera	al Sepvice Licer	alex				ess of Facility Geo	-		ral Hom 2074			
			23a. Part . Enter the di shock, or heart lai	isease, or com ilure. List only									Approximate Interval Between Onset and Death		
	Physician /Medical		Immediate Cause (Fina disease or condition resulting in death)	al .	a Respir	ration	y Fa	Love					Onset and Death		
	Examiner				Due to (or a	s a conseque	(Dice of):	and from	dove						
		ner	Sequentially list condition of any, leading to immediate. Enter Underlying Cause (Disease or injurthat initiated events	ons, diate	Due to (o	s a conseque	ence ol):		vivre l Info						
_		Examiner	Cause (Disease or injur that initiated events resulting in death) Last	y)	e. Acu	s a conseque	Myoc	ardia	l Info	acha	^				
,/0	be ex sicien burial			·	Due to (or a	s a conseque	ence or)								
90	ifficate g phys	edical		_	d										
11522 107 .0. Box	it the death certificate be executed by the ettending physicien and tached for use as the burial-transit	Physician/M	IF FEMALE: 23b. Was decedent pre in the past 12 mon 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	nths?	23c. If yes, outcom 1 Live birth 4 Pregnant 9 Unknown	2 🗀 Fetal o	death 3□	Ectopic pregnancy Other (specify)	у			Date of deliv Month	ery Day Year		
3/21 9/21 rds, P	quires that n signed t uld be det	δ	Part II. Other significan	conditions of		but not resul		, ,	ven in Part I.	1	tobacco use co Yes 2 ☐ No		he cause of death? bably 4 Ponknown		
PoB: PoD:	: The law requires that the cete has been signed by the page 2 should be detache	Completed				•					s an 24t opsy ormed?	o. Were auto prior to co death? 1 ☐ Yes	opsy findings available impletion of cause of		
res Vita	ysician: Th is certificete director, pag	Be (25. Was case referred to examiner?	to medical	Harrison I		_	lou	26. Place of Dea	th Check only	one				
-01.4	Phys this ral dir	.T	1 ☐ Yes 2 ☑ No 27. Manner of Death		Hospital: 1 ☐ Inpa		R/Outpatien 28b. Time of	3 DOA Ott	4 🗆 Nursing F	lome 5 Res	how injury occ		(y)		
126/ 1395 100 0	fing After fune	itlon	/	☐ Pending investigatio	(Month, E	ay Year)	Injury	28c. Injur World M 1	rk? Yes 2 □No	200. 20001100	now injury coo	01.00			
Sivisi Divisi		Certification;		Could not b	e 28e. Place of I	njury - At hon etc. (Specify)	ne, farm, str	eet, factory, office			(Street and Num wn, State)	mber or Rur	al Route Number,		
traule 172-18	To the Hospital or within 24 hours etter To the Funeral Dir completely filled in In		29a. Certifier 1€	Certifying Ph	nysician: To the bes	st of my know	rledge, death	occurred at the til	me, date and place	, and due to the	cause(s) and	manner as :	stated.		
77	the Ho nin 24 h the Fu	edical	(Check only 2 one)	Medical Exar	miner: On the basis and manner	of examinations of examination	on and/or in	restigation, in my o	opinion, death occu	irred at the time					
	ToT ToT	Σ	29b. Signature and title	of certifier				29c. Licens			29d. Date sign		الصاد أنا		
			C HU	ndel	completed saves of	dooth /ltar	220) (7:		61165		septen	wer	26,2007		
CL	(25)	1	30. Name and address Trish Hai	ndel M	ID 9733 H	lealthv	vay Dr		in, Maryl	and 21	811				
	Sta Registr		OCT 0 2	2007	32. Regis	trar's Signat	ed								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** 1210 PM Horper September 27 ongld 2007 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Rockville Mon framery

Birthplace (State or Foreign Shady Grove MO . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 5. Social Security Number 240-74-3861 **Funeral** 10/28/1946 Months Days Hours Min. 1**⊠** M 2□ F Hollister, NC Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location Washington 10d. Inside City Limits 10b. County show 10a. State Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f shov any Injury or other traumatic event, the Medical Examiner must be notified at n/a 1. Yes 2 No Director 10g. Citizen of What Country? 10e. Street and Number 4870 Fort Totten Drive NE 10f. Zip Code #401 20011 USA Funeral Pages 1 and 2 should be filed within 72 hours after death 14 Bace - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ∑XYes 2 ☐ No If Yes, Give 1969—1970 Year or Dates: 1 Never Married 2 Married Specify: Black Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔼 No Specify: þ 3 Widowed 4 Divorced Be Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Private Warehouse Worker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Harper Macco Mary B. Lynch ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joy Etta Harper Fort Totten Drive NE, #401, Wash, DC 20011 20b. Place of Disposition (Name of cemetery, crematory or other place)
Rivercale Park Crematory Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 10/04/2007 Riverdale, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lensee 22. Name and Address of Facility Bianchi 814 Upshur St NW Washington, DC 20011 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Ulmonyr **Physician** Ominutes /Medical Due to (or as a consequence of): Examiner Due (Sibr as a consequence of): Sequentially list conditions, if any learning terms delicated. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical attending ph for use as t IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 🗌 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>}</u> Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an performed? 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Funeral Director: itely filled in by the 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours Te Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier completely and manner stated. within 2 29c. License number 64235 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

of (S)
State

State Registrar

32. Registrar's Signature

DHMH 17 Rev 1/2001

Mal. 9901 Medical Ctr. Dr. Rockille Md

	1	For State	State	of Marylan	-	artment rtificate				giene Reg. No. 🤰 (107	2.2	107	
0.0		Registrar 1. Decedent's Name (First, Middle	Last)			- Invocato	0, 200		2. Date of Dea	ath	14	3. Time of I	eath	
Physicia	n	Yang Zhen Huar							Month Senter	h Day Year btember 29, 2007 7:35 PM				
/Medica	•	la. Facility Name (If not institution	<u> </u>	number)		4b. City, To	wn, or Locati	on of Death	Бороси	4c. County		1		
		Montgomery Hos	spice-Ca	sev House	e	R	ockvi1	1e		Mont	tgomei	ry		
Funeral		Social Security Number	6. Sex	7. Age (In yrs.	last birthday)	If Under 1		der 24 Hrs.	8. Date of Birtl (Month, Day	h /, Year)	9. Birthp Coun	lace (State or	Foreign	
Director		212-51-9432	1□ M 2√2	45	Yrs.				July 30		Ch:	ina		
and	- 1-	Usual Residence of Decedent 10a. State 10b. County		10c. Cit	y, Town or Lo	ocation					1	0d. Inside City	y Limits	
Marylan f show ied at	Director											1 ☐ Yes	2 % No	
r 28a	မှု	Maryland 10e. Street and Number	Mor	tgomery		10f. Zip C	ville ode			10g. Citizen of	What Cour	ıtry?		
h with state of state		12630 Viers N	Mill Roa	d, #207			2085	3			USA			
Ore, Maryland 21215-0036 es 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. fiften 27 is marked other than "natural", or items 23a or 28a-f show in other traumatic event, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 ★ Marri 3 □ Widowed 4 □ Divorced	ed 1 TY	Decedent Ever in U d Forces? es 2 (3x)No , Give or Dates;	.S. 13.	Was Decede If Yes, specif			cify Yes or No- Rican, etc.)	Bla	ce - Americ ck, White, fy: Asia	etc.		
5-0036 72 hours aff natural", or	D D	15. Decedent		Di Dates.		dent's Usual				16b. Kind of B	Business/Inc	dustry		
15.	Completed	(Specify only highes Elementary/Secondary (0-12)	t grade complet	ed) ge (1-4or 5+)	(Give	kind of work DO NOT use	done during retired)	most of worki	ng				-	
212 I with giene r thau		unknown	Colle	je (1-401 5+)	Wait	ress				Resta	aurant	t		
othe office	Re C	17. Father's Name (First, Middle,	Last)				18. M	lother's Name	(First, Middle,	Maiden Surna	me)			
/lar	<u>.</u>	Unknown Huang						Unknow	n					
Maryland 2121 td 2 should be filed within th and Mental Hygiene. 27 Is marked other than " traumatic event, the Men		19a. Informant's Name/Relations				,				er, City or Town		,		
and and lealth m 27 her tr	1	Guo Huan Ye/Hu	ısband	l noh I		O Veir		Road,	#207,	Rockvi.			03	
Baltimore, permit. Pages 1 a Department of Hee mportant: If item ny injury or other or ether and in the more.		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S			cemetery, cre	matory or oth Heaven	er place)	Oct.	2, 2007	Silver	•		yland	
Baltimor permit. Pages Department of Important: If it any injury or o		21. Signature of Funeral Service	Licensee							Home :		g, MD :	20901	
		23a. Part. Enter the disease, or shock, or heart failure. List	complications the	nat caused the dear			_				17	Approximate Interval Bety	veen	
Physician	7/	Immediate Cause (Final disease or condition		eosarcom	а							Onset and D	Death	
/Medical		resulting in death)	d.	e to (or as a consec										
Examiner		Sequentially list conditions	b											
P #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or milery that initiated events	Due	e to (or as a consec	quence of):									
'60, be executed sician and burial-transit	Examine	that initiated events resulting in death) Last	c	e to (or as a consec	uence of):					-	\rightarrow			
bur bur be				(,,-									
687 tiflicate g phys as the	<u>ğ</u>		d											
I Records, P.O. Box 687 The law requires that the death certificate the has been signed by the attending physoage 2 should be detached for use as the	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1□ Yes 2□ No 9□ Unknown	1 □ L 4 □ F	, outcome pf pregn ive birth 2 □ Fet regnant at time of o Inknown	al death 3	□Ectopic pre □ Other <i>(spe</i>				23d. Date of delivery Month Day Year			/ear	
res the digner be d	2	Part II. Other significant condition	ons contributing	to death but not res	sulting in the	underlying ca	use given in F	Part I.		obacco use cor Yes 2 No				
Cord w requir been si	Completed								24a. Was	an 24h	Were auto	opsy findings	available	
II Rec	Ē.								auto _l perfo	psy ormed?	prior to co death?	empletion of ca	ause of	
Vital Fician: The certificate rector, pag		25. Was case referred to medica					26 1	Place of Deat	1□ Yes		1 🗌 Yes	2 No		
or Vital Physician: this certifica	o O	examiner? 1 ☐ Yes 2 ☑ No	Hospital:	1 ☐ Inpatient 2 ☐	ER/Outpatie	ent 3 DOA	Othor:		7	dence 6 110	ther (Speci	(fy) Hosp	ice	
On Or ding Phys a. After this funeral di		27. Manner of Death		Date of Injury (Month, Day Year)	28b. Time Injury	of 28	c. Injury at Work?			how injury occu				
sion ath. or: Aff	atio	1 ☑ Natural 5 ☐ Pendin 2 ☐ Accident investig	gation	monan, Day 1 can,	,,	М	1 ☐ Yes	2□No						
Division I or Attending after death. I Director: After	Certification:	3 ☐ Suicide 6 ☐ Could determ	inod 200. F	Place of injury - At houilding, etc. (Spec	nome, farm, s ify)	treet, factory,	office		28f. Location (City or To	Street and Nurr wn, State)	iber or Rura	al Route Num	ber,	
	edical C	29a. Certifier (Check only one) 1	Examiner: On	o the best of my kn the basis of examin manner stated.	owledge, dea ation and/or	ath occurred a nvestigation,	t the time, da	ite and place, n, death occur	and due to the red at the time,	cause(s) and r date and place	nanner as s	stated. to the cause(s	3)	
o the	Mec	29b. Signature and title of certifie		7		29c.	License num	ber		29d. Date sign	ied (Month,	Day, Year)		
7		Juenione !	Vrolle	av Si	ur)		D6461	.5		October	2, 2	00 7		
5		30. Name and address of person Genevieve Wro	olewski	, MD 60	001 Mur	ncaster	Mill	Road,	Rockvi	lle, MD	2085	55		
Stat Registra		31. Date filed (Month, Day, Year) OCT 0 2	2007	32 Aegistrar's Sigr	ature	noute !								

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death SEPTEMBER Day **Physician** HARRIS KATHERINE /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Shady Grove Adventist Hospital Montgomery Rockville If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🖺 F Months Days Hours Min. Director 577-66-2110 February 28,1909 Indiana 98 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ns 23a or 28a-f show must be notified at 1 ☐ Yes 2 X No Directo Maryland Montgomery Gaithersburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 110 Chevy Chase Street, #403 20878 II.S.A. Funeral death ural", or Items 2 I Ex∍πiner mus 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. Int: If item 27 Is marked other than "natural", or Ite 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: Completed by Caucasian 3 ☑ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 1.2 Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ۵ Christ Barlas Helen Eliapoulos 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau Mary Harris - Daughter 110 Chevy Chase Street, #403, Gaithersburg, Maryland 20878 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Gate of Heaven Cemetery 10/03/2007 Silver SPring, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Avenue, Silver Spring, Maryland 20904 23a. Part1 . Ther the disease shock, or heart failure. ner the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** RESPIRATOR MINUTES /Medical Due to (or as a consequence of): **Examiner** 12 DAYS NEUMON Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last ue to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 Physician/Medical as IF FEMALE: for use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No Month Day 4☐Pregnant at time of death 5 Other (specify) signed by the a d be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by ARTERY DISEASE CORONARY 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 No PERIPHERAL VASCULAR DISEASE 24a. Was an certificate has autopsy CEREBRAL DISEASE 1☐ Yes 2 X No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After t 5 Pending investigation 1 Natural Iniury 1 ☐ Yes 2 ☐ No death. 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation in my calcular death occurred. 29a. Certifier Medical

24 hours after death Funeral Director: Hospital within 2

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9715 MEDICAL CENTER DRIVE FOX KOBERT L.

Registrar

31. Date filed (Month, Day, Year) OCT 02 2007 OCT

(Check only one)

29b. Signature and title of certifier



Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

024713

29d. Date signed (Month, Day, Year)

ROCKVILLE, M.D.

SEPTEMBER 30,2007

		State of Maryland / De State of Maryland / De Per dr., g874,12	partment of Health and M enificate of Death	lental Hygier	2007 33109
6 1		1. Decedent's Name (First, Middle, Last)		2. Date of Death 1	0/01/2007 _{ar} 3. Time of Death
Physicia /Medic		CHARLES LEON HARDY		OCTOBER	2 2007 7:45 P ^M
Examin	er	4a. Fecility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death
		JULIA MANOR HEALTH CARE CENTER 5. Social Security Number 6. Sex 7. Age (In yrs. last birthd)	HAGERSTOWN av) If Under 1 Year If Under 24 Hrs.	8. Date of Birth	WASHINGTON 9. Birthplace (State or Foreign
Funeral Director		219−34−5119 1⊠ M 2□F 68 Yrs	Months Days Hours Min.	(Month, Day, Yea	ar) Country)
		Usual Residence of Decedent			
arylan show	<u>_</u>	10a. State 10b. County 10c. City, Town or	Location		10d. Inside City Limits 1 X Yes 2 □ No
he M	Director	MARYLAND WASHINGTON 10e, Street and Number	HAGERSTOWN 10f. Zip Code	100	Citizen of What Country?
with la or i		333 MILL STREET	21740	, og.	U.S.A.
ms 23	Funeral		Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - American Indian,
after or Ita	Fur	1 Never Married 2 Married 1 Yes, Sive	If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ☑ No Specify:	Hican, etc.)	Black, White, etc.
ours rall,	d by	3 ☐ Widowed 4 ☑ Divorced Year or Dates:			WHITE
"nate	Completed	(Specify only highest grade completed) (G	ocedent's Usual Occupation live kind of work done during most of work e. DO NOT use retired)		Kind of Business/Industry
within than	duic	Elementary/Secondary (0-12) College (1-4or 5+)	DISABLED		DISABLED
a filed I Hyg other	0	17. Father's Name (First, Middle, Last)		e (First, Middle, Maid	
and yearlied Z. I.Z. 100000000000000000000000000000000000	To B	CHARLES EDWARD HARDY	ADDIE M.	HOLMES	
2 sho and Is ma			ailing Address (Street and Number or Run		
1 and 1 and Health em 27 ther tr			O WEST 1st STREET, Sposition (Name of		I, MARYLAND 21740 Location - City or Town, State
Pages 1		1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State	crematory or other place)		
그 문문을 .		* 4 □ Donation 5 □ Other (**Pecify) SAMPILES 21. Signature of Foneral Service Licensee	S MANOR CEMETERY 10, 22. Name and Address of Facility		ARPSBURG, MARYLAND National Pike
permit, Departi Import any inj		Paul M. Dean	BAST FUNERAL HOME		, Maryland 21713
NAME OF TAXABLE		23a. Part1. Enter the disease or complications that caused the death. Do not shock, or heart failure. List only one cause on each line.	enter the mode of dying, such as cardiac		Approximate Interval Between
Physician		Immediate Cause (Final disease or condition	phstyrative		Onset and Death
/Medical Examiner		resulting in death) Due to (or as a consequence of):	+		
Examine	-	Sequentially list conditions,	115 Mellit		
ted nsit	nlne	cause. Enter Underlying Cause (Disease or injury	~ Misare	ALV	
execu n and ial-tra	Examiner	that initiated events resulting in death) Last C. Due to (or as a consequence of):	, , , ,		
cate be executed physician and the burial-transit	dlcal	d			
rtifica ng ph as th	Medi	IF FEMALE:			
w requires that the death certific been signed by the attending should be detached for use as	Physician/Me	23b. Was decedent pregnant in the part 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death	3 □Ectopic pregnancy		23d. Date of delivery Month Day Year
he de the shed f	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 4 ☐ Pregnant at time of death 9 ☐ Unknown	5 Other (specify)		
that the ed by	/ Ph	Part II. Other significant conditions contributing to death but not resulting in the	e underlying cause given in Part I.	23e. Did tobaco	to use contribute to the cause of death?
quires n sign	d by	Dement, a		1 ☐ Yes	2 No 3 Probably 4 Winknown
aw rec	Completed			24a. Was an	24b. Were autopsy findings available prior to completion of cause of
sician: The law scertificate has b lirector, page 2 s	mo			autopsy performed 1 ☐ Yes 2 ₽	? death?
sian: artifica ctor, p	Be C	25. Was case referred to medical examiner?	26. Place of Deat	h (Check only one)	
hysic this ce	၉	1 ☐ Yes 2 ☐ NO Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpa			6 ☐Other (Specify)
Jing F	lon:	27. Manner of Death 1 Natural 5 Pending (Month, Day Year) Inju		28d. Describe how in	njury occurred
Atten deat ctor: y the	Certification;	2 Accident Investigation 3 Suicide 6 Could not be determined determined			and Number or Rural Route Number,
s after il Dire	Serti	4 ☐ Homicide determined building, etc. (Specify)		City or Town, St	ate)
To the Hospitel or Attending Physician: The law requires that the death certification 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending it completely filled in by the funeral director, page 2 should be detached for use as	edical (29a. Certifier (Check only one) 1 Certifying Physicien: To the best of my knowledge, d 2 Medicel Examiner: On the basis of examination and/o	eath occurred at the time, date and place, or investigation, in my opinion, death occur	and due to the cause red at the time, date	e(s) and manner as stated. and place, and due to the cause(s)
To the within To the Somple	Me	29b. Signature and title of certifier	29c. License number	4	Date signed (Month, Day, Year)
		I fail much	2000337	9	10/2/07
5H-3		30. Name and address of person who completed cause of death (Item 23a) (Ty	pe, Print) 1126 0	rale	217/00
			Hagers	form y	MD 11140
Sta Registr		OCT 0 3 2007	Sperke	/	

07-07792 Inez Hollis

Director

or 28a-f show

timore, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2007 33110 Certificate of Death 1. For State Registrar 2. Date of Death 1, Decedent's Name (First, Middle,Last) Month Day October 6, 2007 Physician/ 0017 hrs tollis AMelia al Examiner Fnez 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Baltimore Good Samaritan Hospital If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 7. Age (In yrs. last birthday) If Under 1 Year 5. Social Security Number Funeral Months Davs Hours Country) Maryland 3 8 M 2 V F Yrs 15-18-4758 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a, State 1 Yes 2 No Baltimore traumatic event, the Medical Examiner must be notified at once. Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number imore, MD 21215-0036

Pages I and 2 should be filed within 72 hours after death with th went of Health and Mental Hygiene ant: If item 27 is marked other than "natural", or items 23a or so other traumatic event, the Medical Exemiser. 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Funeral 12. Was Decedent Ever in U.S. 11. Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White etc. Armed Forces? 1 Never Married 2 Yes Specify: Black 1 Yes 2 No specify: If Yes, Give Year 3 Widowed Divorced ⋧ 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed College (1-4 or 5+) Elementary/Secondary (0-12) Domeone else's home 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Millie inkett Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, P ၉ MD. 21213 -Baltimore Edison Highway Shei 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition crematory or other place) Removal from State Vienna, Maryland 1 Burial 2 Cremation 3 10/13/07 permit. Pages
Department of
Important: I Je Sley Church Cemetery 4 Donation 5 Other Specify: 22. Name and Address of Facility
HENRY FUNERAL HOME, P.A.
1510 Washington St. Cambridge 21. Signature of Funeral Service Licensee 23a. Part. Enter the disease, or complications that caused the Math. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or he Approximate Interva Between Onset and Physician failure. List only one cause on each line. Death 'Medical Cystitis with peritonitis Immediate Cause (Final disease _xaminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical X UNPENDED #Z3a,27.perMFg874 12/11/07 TT 23d Date of delivery 23c. If yes, outcome of pregnancy IF FEMALE: Year Month Day 23b. Was decedent pregnant in the Ectopic pregnancy Fetal death Live birth past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 V No 9 Unknown q Unknown 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. Part II. Other significant conditions 1 Yes 2 V No 3 Probably 4 Unknown þ Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy death? performed? 2 No ✓ Yes 2

the attending physician and ed for use as the burial - transit The law requires that the death certificate be signed by the within 24 hours after death.

To the Funeral Director: After this certificate has I completely filled in by the funeral director, page 2 sh To the Hospital or Attending Physician: 'within 24 hours after death. Be ٩ Certification:

Box 68760,

Division of Vital Records, P.O.

1 🗸 Yes 26.Place of Death (Check only one) Other₄ Nursing Home 5 Residence 6 DOA

October 7, 2007

OCIVIE

25. Was case referred to medical Hospital: 1 / Inpatient 2 ER/Outpatient 3 1 ✓ Yes 28d. Describe how injury occurred 28c. Injury at Work? 28b. Time of Injury 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 1 Yes 2 No 1 X Natural Pendina 2 Investigation Accident 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State) 3 6 Could not be Suicide (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 1

2 W Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) 29c. License number 29b Signature and title of certifie

12me 30. Name and a dress of person who completed cause of death (Item 23a)

Margarita Korell MD.

Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

O.C.M.E.

31. Date filed (Month, Day, Year) State Registra

Medical



ORIGINAL

DHMH 17 Rev 1/2001 OCME 2006

			For State Registrar	State of M	aryland / Depa	artment of H			giene	דחח	33111
	pl:	水	1. Decedent's Name (First, Middle, Last	")	·			2. Date of De.	ath Day	Year	3. Time of Death
ling	Physici /Medio		Louise Ann			Hitch		9	21	2007	6:00 P M
	Examir	er	4a. Facility Name (If not institution, give			4b. City, Town, or	Location of De	ath	4c. Co	ounty of Death	
100			800 S. Division S 5. Social Security Number 6. Se		je (In yrs. last birthday)	Salisbu If Under 1 Year		rs. 8. Date of Birt		icomico	place (State or Foreign
	Funeral Director			M 2∭F	77 Yrs.	Months Days	Hours Mi		y, Year)	De 1	place (State or Foreign ntry) aware
4.7	ō		Usual Residence of Decedent					3 13	1730		
	within 72 hours after death with the Maryland ane then "natural", or Items 23a or 28a-f show the Madical Examinat must be notified at	_	10a. State 10b. County		10c. City, Town or Lo	cation				1	Od. Inside City Limits
	Pas-f	Director	MD Wicomic	.0	Salisbur			T	10 000	/ / / / / / / / / / / / / / / / / / / /	1X Yes 2 No
	with t		10e. Street and Number			10f. Zip Code				n of What Cour	ntry?
	ns 23	Funeral	800 S. Division S	12. Was Decedent	Ever in U.S. 13.	2180 Was Decedent of Hi	ispanic Origin?	(Specify Yes or No	US	A Race - Americ	can Indian,
(0	ritten	표	1 Never Married 2 Married	Armed Forces?	No	f Yes, specify Cuba	n, Mexican, Pu	erto Rican, etc.)		Black, White,	etc.
903	ral', c	d by	3 ☐ Widowed 4 ☒ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2,X☐ No	Specify:		Sp	рес <i>ify:</i> Wh	ite
5-0	72 h	Completed	15. Decedent's Edu (Specify only highest grad		(Give	dent's Usual Occupa	during most of w	vorking	16b. Kind	of Business/In	dustry
121	within hen hen	Id II	Elementary/Secondary (0-12)	College (1-4or	5+)	DO NOT use retired)		•		
2	e filed value Hygie other I		1.2 17. Father's Name (First, Middle, Last)		Hom	emaker	18. Mother's N	lame (First, Middle,		Home Imame)	
an	uld be Aental rked o tic sve	To Be	Louise Albert Has	tings				Ann Blanc		,	
Maryland 21215-0036	s 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene. item 27 Is marked other than "natural", or items 23s or 28s-f show other traumatic event, its Medical Examinar must be notified at	-	19a. Informant's Name/Relationship (T)		19b. Maili	ng Address (Street a				own, State, Zip	Code)
	1 and 2 Health a		Jim Hitch - son		7905	Stevens	Road, E	den, MD 2	21822		
Baltimore,	of He of He litem		20a. Method of Disposition	3	20b. Place of Dispo cemetery, crei	sition (Name of natory or other place	e)	Date	20c. Local	tion - City or To	own, State
Ë	permit. Pages Department of P Important: If its any injury or of		1 🔀 Burial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify)		Wicomico I	Memorial	Pk. 9-	28-2007	Salis	bury, 1	Maryland
Salt	permit. Departi		21. Sonature of Ameral Service Licens	300	22	. Name and Addres	ss of Facility B	ounds Fur	eral	Home	
	20 E E G		Jeno)	Lelly		05 E. Mai				yland 2	
-16			23a. Part1. Enter the disease, or comp shock, or heart failure. List only o	lications that caused ne cause on each li	d the death. Do not ent	er the mode of dying	g, such as card	iac or respiratory ai	rest,		Approximate Interval Between Onset and Death
	Physician	1	Immediate Cause (Final disease or condition resulting in death)	a	45	CUD					r
	/Medical Examiner		Todaking in dodain)	Due to (or as	a consequence of):						
		er	Sequentially list conditions, if any, leading to immediate	b. Due to (or as	a consequence of):						
	uted d ansit	Examine	cause. Enter Underlying Cause (Disease or injury that initiated events								
o,	certificate be executed adding physician and use as the burial-transit		resulting in death) Last	Due to (or as	a consequence of):						
8760,	ate be nysicia he bu	dical		d.							
9	ing ph	Med	IF FEMALE:	\							
Вох	death certific le attending p le for use as t	an/	23b. Was decedent pregnant in the past 12 months?		2 Fetal death 3	Ectopic pregnancy			230	d. Date of delive Month	ery Day Year
0.	0 0 0	Physician/Med	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant a 9□Unknown	t time of death 5	Other (specify)					,
۵.	requires that the de neen signed by the hould be detached		Part II. Other significant conditions co	ntributing to death b	out not resulting in the u	nderlying cause give	en in Part I.	23e. Did to	obacco use	contribute to the	he cause of death?
sp.	uires 1 sign 1d be	d by		AIM				1 🗆 1	/es 2□!	No 3 Prob	pably 4 Unknown
COI	> 40	lete						24a. Was	an 2	24b. Were auto	psy findings available
Re	0 5 0	Completed						autop		prior to co death?	mpletion of cause of
Vital Record	ician: Th certificate rector, pag	o o	25. Was case referred to medical				26, Place of D	1 ☐ Yes leath (Check only o		1 🗆 Yes	2L) NO
Ϋ́	Physician: this certific ral director,	To B	examiner? 1 XYes 2 No	Hospital: 1 🗌 Inpatie	ent 2 ER/Outpatier	t 3 DOA Othe	30	Home 5 Resid		Other (Specif	iy)
n of	ding PI h. After ti funeral		27. Manner of Death 1 ★Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	lry 28b. Time o	28c. Injury Work	at c?	28d. Describe h	now injury o	occurred	
sio	Attending ir death. ector: After by the fune	catl	2 Accident investigation 3 Suicide 6 Could not be				Yes 2□No				
Division	after death Director: I in by the	Certification:	4 Homicide determined	28e. Place of Inj building, et	ury - At home, farm, str c. <i>(Specify)</i>	eet, factory, office		28f. Location (S City or Tox		Number or Rura	al Route Number,
_	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific crimplately filled in by the funeral director.		29a. Certifier 1 Certifying Phy	sician: To the heet	of my knowledge, deati	occurred at the time	ne date and cla	ce, and due to the	causa(s) s=	d mannor ac a	tated
	24 h	edical		ner: On the basis of and manner st	f examination and/or in	restigation, in my op	oinion, death oc	curred at the time,	date and pla	ace, and due to	the cause(s)
	To the within To the crmple	Me	29b. Signature and title of pertifier			29c. License	number		_ \	signed (Month,	Day, Year)
) (Shu			145	(7400		91:	2410	
	21M		30. Name and address of person who co	ompleted cause of c	feath (Item 23a) (Type,	Print)		why		, Sal	
-			(hris Suyou	(Q)	E Courc	11 87	\geq	wory	ND 2	100)	
	Sta	1000	31. Date filed (Month, Day, Year) SEP 2 7 20	007 32. Segistr	ar's Signature	and a		,			
1	Registr	ar		人人 工程数数	total Sist field	Marine Stylen					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death P^{M} October 0 2007 1308 Charles Ernest Herd, Jr. 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death 3 Circle Avenue E1kton Ceci1 If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1 M 2 □ F Yrs. 62 NOV 20, 1944 Michigan 218-44-0541 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2 X No Maryland Ceci1 E1kton 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 3 Circle Avenue 21921 United States Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerlo Rican, etc.) 14 Race - American Indian 12. Was Decedent Ever in U.S Armed Forces? 106 11 Marital Status 1 NYes 2 No 1962 − If Yes, Give Year or Dates: 1967 Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify: 3 ☐ Widowed 4 🛣 Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Manufacturing 10 Assembler 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Charles Ernest Herd, Sr. Beatrice Mersino 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marilyn A. Barber/Sister 1898 Old Philadelphia Rd., Elkton, MD 21921 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition October 8, 1 ☐ Burial 2 X Cremation West Chester, 3 ☐Removal from State R.A. Ferris & Co., Inc. 4 ☐ Donation 5 ☐ Other (Specify) Pennsylvania 22. Name and Address of Facility. Hicks Home for Funerals, P.A. 103 W. Stockton Street, Elkton, Maryland 21921 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) grann in Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 1 Yes 2. No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 KResidence 6 ☐ Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident (Month, Day Year) Injury 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No

Physician /Medical Examiner

Physician

/Medical

Directo

Funeral

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Completed

Be

Examiner

Funeral

Director

death with the Maryland

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Madical Examiner must be notified at once.

Maryland 21215-0036

Baltimore,

Examine

led by the attending physician detached for use as the buria has Attending Physician:

Division or Vital Records, P.O. Box 68760,

Physician/Medical <u>\$</u> Completed

Be P Certification:

124 hours after death. e Funeral Director: After thi letely filled in by the funeral To the I within 2.

7+1

State Registrar

Medical

22 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. ertifie 29b. Signature and

30. Name and addre

6 ☐ Could not be

determined

3 ☐ Suicide

29a. Certifier

4 ☐ Homicide

(Check only one)

ASH OIL

31. Date filed (Manth, Day, Year)

29c. License number

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

es of person who o mot ted cause of death (item 23a) (Type, Print) SUBTANATION

32. Registrar's Signature

, M.D., 106 Bow St., Elkton, MD 21921

🛮 🗀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene 007 33113 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** SEPT. 28 2007 4:15 P M ICKES CAROLYN RETH /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner **QUEEN ANNE** CENTREVILLE 224 BROADWAY 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplece (State or Foreign
Country) 6. Sex **Funeral** Months 1 ☐ M 2 🕱 F MARYLAND MARCH 24,1943 Director 218-40-8995 64 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County or 28e-f show Examiner must be notified at 1 X Yes 2 □ No QUEEN ANNE CENTREVILLE MD Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a USA 21617 224 BROADWAY Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. snt: If item 27 is marked other than "naturel", or ite 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 WHITE 1 ☐ Yes 2X No Specify: Specify. Completed by 3 Widowed 4 Divorced Year or Dates: the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) STATE OF MARYLAND COURT COMMISSIONER 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be LILLIAN BIRKHEAD PETER HENRY RETH 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 224 BROADWAY, CENTREVILLE, MD 21617 GEORGE E. ICKES/ HUSBAND other 20b. Place of Disposition (Name of 20c. Location - City or Town, Stete 20a. Method of Disposition CHESAPEAKE CREMATION 6 1 ☐ Burial 2 Cremation 3 ☐ Removal from State permit. Page Department of Importent: If any injury or 10-01-2007 * 4 ☐ Donation 5 ☐ Other (Specify) STEVENSVILLE, MD CENTER 21. Signatura of Funeral Service Licensee FELLOWS, HELFENBÉIN & NEWNAM FUNERAL HOME, P.A. TYTIAS Cuplen 408 S. LIBERTY ST., CENTREVILLE, MD Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition nculatic Cancer **Physician** a resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospitel or Attending Physicien: The law requires that the death certificate be executed and Due to (or as a consequence of): Box 68760 attending physician Physician/Medical as the 23c. If yes, outcome of pregnancy 1□Live birth 2 □Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy detached for Day Year 4☐ Pregnant at time of death 5 Other (specify) Ö 9 Unknown 9 Unknown ģ Division of Vital Records, P. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ pe 4 Unknown 1 ☐ Yes 2 ☐ No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5X Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient ို 2 ER/Outpatient 3 DOA in by the funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After Certification: 5 Pending investigation Natural 1 ☐ Yes 2 ☐ No death. 2 Accident 24 hours after deatl Funerel Director: 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifie and manner stated o the the 29d. Date signed (Month, Day, Year) 29b. Signatury and title of certific 29c. License number 0 Physiaan 4005 7021 30. Name and addres of person who completed cause of death (Item 3a) (Type, Print) VALERIE GOODMAN, D.O. 10 OTRU 32. Registar's Signature 31. Date filed (Month, Day, Year) State 2007 Registrar

DHMH 17 Rev 1/2001

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	Physici /Medi		1. Decedent's Name (First, Mide ISABEL JANE	JONES						27 2	Year 2007	3. Time of Death 3:30 A ^M
	Examir	ner	4a. Facility Name (If not institution 104 TILGHMAN	AVE., APT.	203			EVILLE		QUEE	N ANN	
	Funeral Director		5. Social Security Number 043–12–8866 Usual Residence of Decedent	6. Sex 1 □ M 2 X F	85	s. last birthday) Yrs.	Months Days	If Under 24 Hrs. Hours Min.		, 1922	9. Birthp Court	place (State or Foreign htry) ECTICUT
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	th with the Maryla 23a or 28a-f ehov	al Director	10e. Street and Number 104 TILGHMAN	AVE., APT.	#203		10f. Zip Code 21617	7		10g. Citizen o		itry?
9036	filed within 72 hours atter death with the Maryland Hygiene. wher then "naturel", or Items 23a or 28a-f ehow ont, the Modical Examitier count by notified	t by Funeral	11. Marital Status 1 □ Never Married 2 □ Ma 3 ▼ Widowed 4 □ Divorce	Armed Formed 1 Tes	2 X No		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 No	dispanic Origin? (S an, Mexican, Puerl Specify:	pecify Yes or No- to Rican, etc.)	14. R B	ace - Americ lack, White, city:	etc.
21215-0036	within 72 h ene. than "natu	Completed	(Specify only high Elementary/Secondary (0-12)	_ ·	1-4or 5+)	(Give	dent's Usual Occup kind of work done DO NOT use retired	during most of wor	rking	18b. Kind of		dustry
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Maryland	5 # C #		19a. Informant's Name/Relation PAUL R. JONES				ng Address (Street					
Baltimore,	permit. Pages 1 and Department of Healt Importent: If item 2 eny injury or other once.		20a. Method of Disposition 1 Burial 2 MCremation 4 Donation 5 Other (21. Signatur 1 uneral Service	Specify)	State CF	NTER	sition (Name of natory or other place CREMAT 2. Name and Addre LLOWS, HEI		8–2007	20c. Location STEVEN:	SVILLE	E, MD
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مالع المال جينمه ع Division of Vital	il or Attending Physician: 1 after death. I Director: After this certificat d in by the funeral director, p	Certification; To Be	3 ☐ Suicide 6 ☐ Could	Hospital: 1 28a. Date (Monting tigation Inot be 28e. Place	of Injury oth, Day Year)	ER/Outpatien 28b. Time of Injury home, farm, str	28c. Injun Wor	er: 4 □ Nursing H	ath (Check only or lome 5 Reside 28d. Describe he 28f. Location (S City or Town	ence 6 00	urred	,
٥	To the Hospital or At within 24 hours after or To the Funeral Direct completely filled in by	ledical Cel	29a. Certifier 12 Certify (Check only one)	ng Physician: To the I Examiner: On the b and man	e best of my ka	nowledge, death	n occurred at the tin	ne, date and place pinion, death occu	o, and due to the corred at the time, d	ause(s) and r ate and place	manner as st	ated. the cause(s)
	To the within To the comple	Me	29b. Signature and title of certifi		6 1	(4)	29c. Licens	e number	3	9d. Date stor	ned (Month)	Day, Year)
			30. Name and address of person ERIC F. CIGANE	ж, М.D.,			Print) VENUE, C	ENTREVIL	LE, MD 2	617	k	
	Sta Registr	100	31. Date filed (MgHE, Payo) ee	2007	Registrar's Sign	nature do	we)					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death September 28 Physician 2007 07:00 Рм Marguerite M. Kerge /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Crofton Crofton Convalescent & Rehab. Center If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 08/20/1922 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours 1 □ M 2√ F 85 Pennsylvania 187-18-1830 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State notified 1 ☐ Yes 2 No Crofton Maryland Anne Arundel Director 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or United States 21114 1172 Jeffrey Drive death ural", or items 2 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ②No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or ite 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: White Completed by 3 X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry the Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Marie Reister William Reynolds ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Audrey C. Kerge/Sister In Law 1172 Jeffrey Drive, Crofton, Maryland 21114 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition ö 1 Burial 2 □ Cremation 3 □ Removal from State permit. Page Department of Important; If any injury or Washington National Cem. 10/02/2007 Suitland, Maryland 4 Donation 5 Dother (Specify) 22. Name and Address of Facility George F. Kalas Funeral Home, F.A. 21. Signatu 6160 Oxon Hill Road, Oxon Hill, Maryland 20745 23a. Hart. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a conseque Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine or Attending Physician: The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical the attending pl 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4 ☐ Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 Unknown ate has been signed page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 Probably 4 □Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an was a. autopsy performed?

Ves 2 No certificate has 1☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA Medical Certification: To funeral c 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 ☐ Pending investigation 1 Natural Injury 1 Yes 2 No 2 Accident s after death.

if Director: / 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide filled in Hospital within 24 hours a

To the Funeral |
completely filled 1 Secretifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar

DHMH 17 Rev 1/2001

29a. Certifier (Check only

29b. Signature and title of cer

(Month, Day,

son who completed cause of death (Item 23a) (Type, Print)

Registrar's Signatu

29c. License number

29d. Date signed (Month, Day, Year)

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			Sacred Heart Home	Nursir	ng Cente	r			Hyatt				ice Geo	
	Funeral Director		5. Social Security Number 6. S 502–09–4603	9x □M 2√2 F	7. Age (In yrs. la 91	st birthday) Yrs.	If Under Months	1 Year Deys	If Under Hours	Min.	8. Date of Bird (Month, Da March 2	th y, Year) 26, 1916	9. Birthplace Country) North	(State or Foreign Dakota
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020	within 72 hours after death with the Maryland ane. than *natural', or items 23e or 28e-f show the Marical Examiner must be notified at	by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 Widowed 4 ☐ Divorced	12. Was Dece Armed Fo 1 Yes If Yes, Giv Year or De	2 ☑ No ′e		Was Deced If Yes, spec 1 ☐ Yes 2				ecify Yes or No Rican, etc.)	14. Rad Bla Specif	ce - American I ck, White, etc. y: Whi	
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Mary			19a. Informant's Name/Relationship (7) Joseph S. Kelley		Son		_				el Route Numbe			de)
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Records,	aw requires as been sign 2 should be	Completed by									24a. Was perfo	en autopsy rmed?	availat	autopsy findings de prior to ation of cause h?
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Division	To the Hospital or Attend within 24 hours aftar deatt To the Funeral Director: completely filled in by the	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place buildin	of Injury - At hom ng, etc. (Specify)	ne, farm, str			163 2	140	28f. Location (5 City or Tox		ber or Rural Ro	ute Number,
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Registrar DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Year September 22, 2007 9:30 Kenyon Judith Diane 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Montgomery 9925 Julliard Drive Bethesda If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Hours Days 1 ☐ M 2 🔯 F 26, 1951 56 Feb.

Baltimore, Maryland 21215-0036 **Physician**

Physician

/Medical

Examiner

The law requires that the death certificate be executed sate has been signed by the attending physician and page 2 should be detached for use as the burial-trar or Attending Physician: director,

Division or Vital Records, P.O. Box 68760,

Funeral Mississippi Director 216-58-8110 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show ral", or items 23a or 28a-f shov Examiner must be notified at 1 ☐ Yes 2 ☑ No Director Bethesda Maryland Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code permit. Pages 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or items 23a or 1 important: if Item 27 is marked other than "natural", or items 23a or 1 important; if Item 27 is marked other than "natural", or items 23a or 1 important; if Item Medical Examiner must be none. 9925 Julliard Drive 20817 United States Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 If Yes, Give 1 ☐ Never Married 2 ☑ Married 2 No Specify: Caucasian 1 ☐ Yes 2 ☐ No þ If Yes, Give Year or Dates: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 5+ Dir, of Policy Integration 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Rhoda Golden Bernard Marlon Engleberg 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9925 Julliard Drive, Bethesda, MD 20817 Bob Kenyon-Spouse 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory Sep 27, 2007 Alexandria, VA 22. Name and Address of Facility Simple Tribute 21. Signature of Funeral S ce Licensee 1040 Rockville Pike, Rockville, MD 20852 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) VETTAN /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☑ No Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Tes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an autopsy 1∐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death Check only ne Certification: To Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 TYes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA s after dec... 27. Manne of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Y atural Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide within 24 hours a 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0060812 MO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Robert ST Phipps 281 BALTO ND whole IT Walk 20 32 egistrar's Signature 31. Date filed (Month, Day, Year) State OCT 02 2007 Registrar

DHMH 17 Rev 1/2001

To the Hospital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Morris KOLKER 2007 October 9:26 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Holy Cross Hospital Silver Spring Montgomery If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 579-40-0147 Days 81 July 4, 1926 Washington, DC Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County Silver Spring 1 ☐ Yes 2 No Maryland Montgomery 10f. Zip Code 20906 10g. Citizen of What Country? 10e. Street and Number 12713 Saddlebrook Place United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ∑Yes 2 □ No Army Ir Yes, Give Year or Dates:WW II 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify. Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Sales Liquor Store 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Ida Strayer Abraham Kolker 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4603 Buckhorn Ridge, Fairfax, VA 22030 Allan Kolker, Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐XBurial 2 ☐ Cremation 3 ☐ Removal from State Mt. Lebanon Cemetery 10/03/07 Adelphi, MD 4 Donation 5 Dother (Specify) 21. Si nature principeral Se vice Lic, nsee Torchinsky Hebrew Funeral Home 254 Carroll St., NW, Washington, DC 20012 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death YEARS Immediate Cause (Final disease or condition resulting in death) Atherosclerotic Cardiovascular Disease Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of) Due to (or as a consequence of) IF FEMALE:

Physician /Medical Examiner Examiner

Physician

Examiner

Funeral

Director

r 28a-f show notified at

Director

Funeral

Completed by

Be

2

filed within 72 hours after death with the Maryland Hygiene. Ither than "natural", or items 23a or 28a-f show

permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or any injury or other traumatic event, the Medical Examiner must be a

Baltimore, Maryland 21215-0036

/Medical

physician and sthe burial-trans page 2 s

/Medical

After this funeral of Hospital or Attending death. n 24 hours a er death.

The Funeral Director A sletely filled in by the filled in by the filled in t

Division or Vital Records, P.O. Box 68760

within 24 hor To the Fune completely f

Joseph	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 Live birth 2 Fett 4 Pregnant at time of 9 Unknown	al death 3 □Ectopic			3d. Date of delivery Month Day Year
ed by Pr	Part II. Other significant conditions	contributing to death but not res	sulting in the underlying	cause given in Part I.	23e. Did tobacco us	se contribute to the cause of death? No 3 Probably 4 Unknown
Complete					24a. Was an autopsy performed? 1∐ Yes 2 X No	24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No
š	25. Was case referred to medical examiner?			26. Place of De	eath (Check only one)	
0	1 ☐ Yes 2X No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3 ☐ [OOA Other: 4 Nursing	Home 5 ☐ Residence 6	□Other (Specify)
ation:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigatio	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury	occurred .
SELLIC	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined			pry, office	28f. Location (Street and City or Town, State)	d Number or Rural Route Number,
cal		hysician: To the best of my known miner: On the basis of examination				and manner as stated. place, and due to the cause(s)

29c. License number

D0043539

29d. Date signed (Month, Day, Year)

20910

2007

Registrar

State

Medical

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

OCT

02

DHMH 17 Rev 1/2001

and manner stated.

Raymond White, M.D., 1500 Forest Glen Road, Silver Spring, MD

32. egistrar's Signature

30. Name and a ld ess of person who completed cause of death (Item 23a) (Type, Print)

2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** ptember 28 Dorothy Bohne Kennedy 2001 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** Prince George's Doctors Community Hospital Lanham If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min 1 DM 2 F 578-30-8877 82 15, 1925 Indiana Director Aug. Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ns 23a or 28a-f show must be notified at 1 ☑ Yes 2 ☐ No Director Marvland Prince George's Greenbelt 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 119 Hedgewood Drive 20770 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married 'natural', or 1 ☐ Yes 2 🙀 No Specify: Specify: White If Yes, Give Year or Dates: þ 3 ➡Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) or other traumatic event, the 12 Administrator Health Care is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be nent of Health and Mental William Ernest Bohne Agnes Bergman 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important; If item 27 is
any injury or other trau Craig F. Kennedy/Son 11925 Galaxy Lane, Bowie, MD 20715 20b. Place of Disposition (Name of cemetery, crematory or other place) October 20c. Location - City or Town, State 20a. Method of Disposition Gate of Heaven Cemetery 2007 4 ☐ Donation 5 ☐ Other (Specify) Silver Spring, Maryland 21. Signature funeral Service License 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd, W, Silver Spring, MD 20901 tions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, cause on each line. 23a. Part1. Enter the disease, or complice shock, or heart failure. List only one Onset and Death Immediate Cause (Final sepsis **Physician** resulting in death) /Medical Due to (or as a consequence of): fisillation Examiner Africa! Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner jaundice Obstructive that initiated events resulting in death) Last attending physician and Due to (or as a consequence of): Physician/Medical as IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 1□Yes 2⊿No the 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No has autopsy performed certificate 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 2 1 Yes this 28a. Date of Injury (Month, Day Year) 28h. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident after death 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 THomicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

death certificate be executed Division or Vital Records, P.O. Box 68760, Hospital or Attending Physician; completely filled in by the funeral To the Hospital within 24 hours at To the Funeral D

Baltimore, Maryland 21215-0036

DHMH 17 Rev 1/2001

State

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

30. Name and address of person who cor

pleted cause of death (Item 23a) (Type, Print)

29c. License number

00065909

29d. Date signed (Month, Day, Year)

Amend 10c Per FH 10-02-2007 CNM if it is a sequence of Death State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** BRIGITTE Т. KING Sept. 2007 7:30 P M /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner 8398 Buckeye Ct. Frederick Frederick Birthplace (State or Foreign Country) 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 M 2 K F 216-11-8977 9, 54 DEC. 1953 Bone Algeria Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show ıral", or Items 23a or 28a-f shov I Examiner must be notified at Frederick 1 ☐ Yes 2 X No Director Maryland Frederick ederick 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 8398 Buckeye Ct. 21702 United States Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗷 No White Specify: þ 3 Widowed 4 Divorced "natural" Completed permit. Pages 1 and 2 should be filed within 72 h
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natu
any injury or other traumatic event, the Medical
once. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Teacher Public School System 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be D'Agostino Norbert Mercedes Balnester 5 4 1 ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 8398 Buckeye Ct./ Frederick, Maryland Wayne King / Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Stauffer Crematory 09/30/2007 Frederick, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Stauffer Funeral Home 1621 Opossumtown Pike, Frederick, MD 21702 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immedia Cause (Final **Physician** years disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence or) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1☐Live birth 3 ☐Ectopic pregnancy 2 Fetal death Day in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2XNo the 9□Unknown 9 Unknown á Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 Yes 2 No 3 Probably 4 Unknown page 2 should Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy perform certificate 2 No 1 ☐ Yes 2 ☐ No 1∐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 A Residence 6 Other (Specify) 1 ☐ Yes 2 X No 2 ER/Outpatient 3□ DOA 2 1 ☐ Inpatient this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural 5 ☐ Pending investigation 1 Tes 124 hours after death.

The Funeral Director: A pletely filled in by the filled in the 2 Accident 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Exertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ohns Hopkins Hos Year) 31. Date filed (Month, Day, State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2007 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Paul William Kimble 09 วีดี 07 1135 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner WMHS-Braddock Campus Cumberland Allegany If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) APR • 24,1929 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday **Funeral** Days Months Hours Min. 78 MARYLAND Director 234-36-7 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits ortant; If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 1 □Yes 2 No FORT ASHBY Director WV MINERAL 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? U.S.A. 26719 ROUTE 28 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 72 hours after 1 Never Married 2 Married 2 **X**No 1 ☐ Yes 2**X** No Specify 2 Specify: WHITE 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) MACHINIST RAILROAD 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ould be f SUMMERFIELD ZACH KIMBLE CARRIE ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 st Department of Health and Important: If item 27 is n any injury or other traun NORMA MAE KIMBLE / WIFE P.O. BOX 207, FORT ASHBY, WV 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 □Removal from State 4 □ Donation 5 □ Other (Specify) FORT ASHBY CEMETERY 10/04/2007 FORT ASHBY, WV 21. Signature of Funeral Service Licenses 22. Name and Address of Facility UPCHURCH FUNERAL HOME, P.A. 202 GREENE STREET, CUMBERLAND, Depella 21502 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** Intracranial Hemorrhage 10 days disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Fall from Stoop Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner burial-trar Due to (or as a consequence of) physician Physician/Medical the IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a d be detached f 9 I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>Ş</u> Congestive Heart Failure 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ★ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an Hypertension autopsy performed? 1□ Yes 2√ No certificate has Coronary Artery Disease 25. Was case referred to medical examiner? director. 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ပ this funeral 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: After 5 ☐ Pending investigation Injury 1 🗌 Natural 1 ☐ Yes 2 ☑ No death. 2 X Accident 09/20/07 1335 Fall 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Box 68760 P.O. Records, Division or Vital

Maryland 21215-0036

Baltimore,

death certificate be Hospital or Attendi 24 hours after death. Funeral Director: A filled in by the within 24 hours a To the Funeral C

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the

Medical

State Registrar

wer

Home

and manner stated.

29c. License number

15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

Route 28, Fort Ashby, WV 26719

Name and address of person who completed cause of death (Item 23a) (Type, Print)

TAYLOR LIVENGOOD MD 912 SETON DRIVE CUMBERLAND MARYLAND 21502

29a. Certifier



			For State Registrar	State of Maryland	-	artment of the		nd Mental I	Hygiene Reg. No.	007	33122
	Physici	an	1. Decedent's Name (First, Middle, Last)					2. Date o Month		2007	3. Time of Death
	/Medic	al	James C. 4a. Facility Name (If not institution, give s	Lott		4b. City, Town, o	or Location of			ounty of Death	10:00 P.M
	Examin	er	7242 Hylton St			Seat P				.G.	
	Funeral Director		5. Social Security Number 6. Sex 579-64-2613		ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hours	Min. 8. Date o	Birth 5 - 1947	9. Birthp Cour Was	place (State or Foreign
	land ow		Usual Residence of Decedent 10a. State 10b. County	10c. City	, Town or Lo	cation				1	0d. Inside City Limits
	e Man	ctor	MD P.G.	Sea	t Ple	easant					1 ☐ Yes 2 🙀 No
	th with the 23a or 28	al Dire	10e. Street and Number 7242 Hylton St	reet		10f. Zip Code 207	43			en of What Cour ced St	
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: if item 27 is marked other than "natural; or items 23a or 28a-f show any injury or other treumetic event, the Medical Exam, and the Lydiffed and ODGe.	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S Armed Forces? 1	ŀ	Was Decedent of I f Yes, specify Cub I ☐ Yes 2 🖾 No	dispanic Origi an, Mexican, Specify:	n? (Specify Yes o Puerto Rican, etc.)	Black, White,	
21215-0036	ithin 72 ho ne. nan "natur nedicul	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12) 1 2 t h	cation e completed) College (1-4or 5+)	(Give life. L	lent's Usual Occu kind of work done DO NOT use retire Ck driv	during most o d)	of working		of Business/In	
	d be filed w ntal Hygier ed other th	Be	1 Z t n 17. Father's Name (First, Middle, Last) Ester Lott			ZK GIIV	18. Mother	s Name (First, Mic rl Warr	ddle, Maiden Si		
Maryland	id 2 should th and Me 27 is mark treumatic	T ₀	19a. Informant's Name/Relationship (Ty, Annette Lott (W		19b. Mailir 7242	ng Address (Street Hylton	and Number Stre	or Rural Route No	umber, City or 1	Town, State, Zip	Code) MD. 20743
Baltimore,	Pages 1 ar ent of Hea nt: ff item ? ry or other		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify)	i ne	metery cren	sition (Name of natory or other pla ection (ce) Cem. 9	Date /29/07		ation - City or To	own, State Maryland
Balti	permit. I Departm Importer any inju		21. Signature of Funeral Service Ucense		22	. Name and Addre	ss of Facility				treet NE .C.20002
	Pnysician	2 1	23a. Part1. Poter the disease, or complishock, or flear failure. List only or Immediate Cause (Final disease or condition	cations that caused the death ne dayse on each line. Squamous							Approximate Interval Between Onset and Death 5½ Vrs.
ı	/Medical Examiner		resulting in death)	Due to (or as a consequ				- 11/1110			
	acuted tnd transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequ							
8760,	cate be executed obysician and the burial-transit	cal	rossining in obtain, East	Due to (or as a consequ	ence or):	······································					
.O. Box 68	that the death certifica ed by the attending ph detached for use as th	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregnar 1□Live birth 2□Fetal 4□Pregnant at time of de 9□Unknown	death 3	Ectopic pregnanc Other (specify)	у		23	d. Date of delive Month	ery Day Year
S, D	quires that n signed by		Part II. Other significant conditions con	ntributing to death but not resu	Iting in the ur	nderlying cause gr	ven in Part I.		Did tobacco use		ne cause of death?
Vital Record	The law requires that the ate has been signed by the page 2 should be detache	Completed						—	Was an autopsy performed?		psy findings available mpletion of cause of 2 No
/ita	Physicien: this certificanal director, I	Be	25. Was case referred to medical examiner?	lospital:		0#		of Death (Check o			
	ling Phys After this cluneral dir	lon: To	27. Manner of Death 1 🛣 Natural 5 🗆 Pending	28a. Date of Injury (Month, Day Year)	ER/Outpatien 28b. Time of Injury	28c. Inju Wo			Residence 6 (ibe how injury o		y)
Division of	To the Hospital or Attending Physicien: The lav within 24 burus after death. To the Funerel Director Atter this certificate has completely filled in by the funeral director, page 2	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	me, farm, str		142 5	28f. Locati	on (Street and a Town, State)	Number or Rura	d Route Number,
	To the Hospital or within 24 hours afte To the Funerel Dir completely filled in	edical C	29a. Certifier (Check only one) 1 Certifying Physical Cartifying Physical Examination (Check only one)	sician: To the best of my knowner: On the basis of examinat and manner stated.	vledge, death ion and/or inv	n occurred at the ti vestigation, in my	me, date and opinion, death	place, and due to occurred at the ti	the cause(s) a me, date and p	nd manner as s lace, and due to	tated. the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	Dall		29c. Licen. D – 1	se number		29d. Date	signed (Month,	Day, Year)
-	(5)		David J. Ha	mpresed cause of death (Item aidak MD 8926	Woodya		Clintor	n, Md. 20	735		
	Sta Registr		31. Date filed (Month, Day, Year) OCT 0 2 2007	32. Registrar's Signat	ure						

DHMH 17 Rev 1/2001

Physician
^o /Medical
Examiner

Funeral

Director permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

Lilly, Lawritta Division or Vital Records, P.O. Box 68760, ひ

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

•	State Registrar		Cert	ificate of D	eath		Reg. N	o.			
	Decedent's Name (First, Middle, Last)					2. Date of De		V	3. Time of Death		
1	Lauritta W. Lilly					Month Sept. 1		2007	10:05 a M		
	4a. Facility Name (If not institution, give s	street and number)		4b. City, Town, or Location of Death 4c. County of Death							
	Collingswood Nursi	ing and Rehab		Rockvil	le		Mo	ntgomery	7		
	Social Security Number 6. Sex	7. Age (In yrs. la	01 011 111 110 117	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da	h	D Bid	thplace (State or Foreign buntry)		
	290-20-4207	M 2 XF 96	Yrs.					6,1910 F	Kentucky		
-	Usual Residence of Decedent 10a. State 10b. County	10c. City.	Town or Loca	ation					10d. Inside City Limits		
_									1√∑Yes 2 No		
	Maryland Montgomer	y Rocky	ville	10f, Zip Code			10a C	itizen of What Co	ountry?		
5	10e. Street and Number										
2	299 Hurley Avenue	12. Was Decedent Ever in U.S	13 W	20850	panic Origin? /Si	necify Ves or No		ted Stat			
5	11. Marital Status 1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 ☑ No	if \	as Decedent of His Yes, specify Cuban	, Mexican, Puert	o Rican, etc.)		Black, Whit	e, etc.		
'n	3 ☑ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	1[☐Yes 2xx No	Specify:			Specify: Whi	ite		
balaid	15. Decedent's Edu		16a. Decede	nt's Usual Occupat	tion		16b.	Kind of Business	/Industry		
2	(Specify only highest grade Elementary/Secondary (0-12)	e completed) College (1-4or 5+)	life. DO	ind of work done du O NOT use retired)	iring most of wor	king					
ē	Elementary/Secondary (5 12)	5+	Micro	biologis	t			Medicine	<u> </u>		
Se l	17. Father's Name (First, Middle, Last)				18. Mother's Nam	ne (First, Middle,	Maide	en Surname)			
0	Joseph Winchester				Sally Ru	ıtherfor	d_				
	19a. Informant's Name/Relationship (Ty		ı -	Address (Street ar							
	Mercia Cassell Dec										
1	20a. Method of Disposition 1 □XBurial 2 □ Cremation 3 □ F	20b. Pla	ace of Disposi emetery, crema	tion (Name of atory or other place)	Date	20c.	Location - City or	Town, State		
	4 □ Donation 5 □ Other (Specify)	Parl	klawn (Cemetery	9-24	4-2007	Roc	kville,	MD		
	21. Signature of Fune al Service Licens	ee		Name and Address					-		
	W.S.(#			10 Rockvi				e, MD 20			
	23a. Part1. Enter the disease, r compl shock, or heart failure. List only of	ications that caused the death. ne cause on each line.	. Do not enter	r the mode of dying	, such as cardiad	or respiratory a	rrest,		Approximate Interval Between Onset and Death		
ı	Immedia e C. use (Final disease ndition	a. Multi-organ							months		
	resulting in death)	Due to (or as a consequ	ence of):	-					months		
	Sequentially list conditions.	Myocardiopat							years		
l le	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequent	ence of):								
Ехашпе	that initiated events resulting in death) Last	Due to (or as a consequence	once of:						years		
	rosulting in doubly Edds	Due to (or as a consequi	ence oi):								
Medical		d									
Me	IF FEMALE:	23c. If yes, outcome pf pregnar	nov		-			Ood Date of de	liven		
au	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de	death 3 □	Ectopic pregnancy Other (specify)				23d. Date of de Month	Day Year		
Physician	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	9☐ Unknown	aui J	Спот (эрсону)							
	Part II. Other significant conditions co	ntributing to death but not resu	Iting in the und	derlying cause giver	n in Part I.	23e. Did	tobacc	o use contribute t	to the cause of death?		
ò	Osteoporosis					10	Yes	2 ∑ No 3□P	robably 4 Unknown		
Completed by						24a. Was	an	24h Were a	utopsy findings available		
Ē						auto		prior to	completion of cause of		
	05.10				20 DI (D	1□ Yes	_ 3 √X′		s 2 No		
De	25. Was case referred to medical examiner?	Hospital:	ER/Outpatient	Othor	r·	ath (Check only		c Dother (Co	if sl		
0	1 ☐ Yes	28a. Date of Injury	28b. Time of	28c. Injury Work		28d. Describe		6 ☐Other (Spe jury occurred	еспу)		
lon	Matural 5 ☐ Pending	(Month, Day Year)	Injury		? ′es 2 □ No						
ca	3 Suicide 6 Could not be	28e. Place of injury - At hor building, etc. (Specify	me, farm, stre	et, factory, office		28f. Location (Street	and Number or F	Rural Route Number,		
erri	4 ☐ Homicide determined	building, etc. (Specify	")			City or To	wn, St	ate)			
Medical Certification:		rsician: To the best of my know iner: On the basis of examinat and manner stated.									
Me	29b. Signature and title of certifier			29c. License	number			Date signed (Mor			
	* Laman	K. Tu	0.	0190	609		9	.21.07	7		
	30. Name and address of person who c	ompleted cause of death (Item	23a) (Type, P	Print)							
	Raman R. Tuli, MD.				a 202 ('aithora	hur	~ MD 20	1070		

State

Registrar

Sparte

2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** Year 12:00 pM September 29, 2007 Bernice Levine /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Suburban Hospital Montgomery Bethesda 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 □ M 2 🖺 F Director 093-22-7684 August 29, 1925 New York Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f shov event, the Medical Examiner must be notified at 1 ☐ Yes 2 📉 No Director Maryland Montgomery Potomac 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Pages 1 and 2 should be filed within 72 hours after death with nent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or? U.S.A. Funeral 8505 Buckhannon Drive 20854 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 □ Never Married 2 N Married altimore, Maryland 21215-0036 1 ☐ Yes 2 🌣 No If Yes, Give Year or Dates: Specify White þ Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 4 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Eli Shaw Lena Weinstein ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health an Important: If Item 27 is s any injury or other trausone. Eric Levine - Son 6733-C South Clifton Road, Frederick, Maryland 21703 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 x Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) King David Memorial Gardens 10/02/2007 Falls Church, Virginia 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Hines-Rinaldi Funeral Home, Inc 11800 New Hampshire Avenue, Sil Silver Spring, Maryland 20904 plications that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest one cause on __ch line. 23a. Part1. Enter the disease, or conshock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death) **Physician** 115/ IVation /Medical as a consequence of) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Division or Vital Records, P.O. Box 68760 Due to (or as a consequence of): attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 2 Fetal death 3 Ectopic pregnancy Day 5 Other (specify) 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 2 PNo 3 Probably 4 ☐Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed? certificate 1☐ Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 2 No 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) Injury 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

9/29/by @ 1200 pm EVINE, BERNICE

Registrar

Medical

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

02

2007

29b. Signature and his of gertifier

29a. Certifier

(Check only

Atul Rohatgi, M.D., 9901 Medical Center Drive, Shady Grove, Maryland 20850 32. Pegistrar's Signature

within 24 hours a

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

V0061307

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** 3, 2007 Carolyn Hill Leggett October 05:10 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Williamsport
If Under 1 Year If Under 24 Hrs. Homewood Retirement Center Washington 5. Social Security Number If Under 1 Year Months Days 8. Date of Birth (Month, Day, Year) Age (In yrs. last birthday Funeral Birthplace (State or Foreign Country) Months 1 □ M 2 🗹 F Hours Director 223-10-4824 93 Jan 30, 1914 Virginia Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits r 28a-f show notified at 1 ☐ Yes 2 🗷 No Directo Maryland | Washington Williamsport 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? than "natural", or items 23a or the Medical Examiner must be r 16505 Virginia Ave 21795 U.S.A. death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 11 Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗷 No þ 3 XWidowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Domestic permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If them 27 is marked other any injury or other traumatic event, once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Carrie McCallum J. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carrie Hopp / Daughter 3314 Carlisle Dr. Knoxville, Maryland 21758 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Rest Haven Cemetery 10/6/2007 Hagerstown, Maryland 22. Name and Address of Facility Rest Haven Funeral Chapel 21. Signature of Funeral Service I 1601 Pennsylvania Ave Hagerstown Maryland 21742 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause a each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician and for use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 pe Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy igned by the atter in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 I Inknown 9 Unknown significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 □ No 1 Yes 2 No 1 ☐ Yes Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3□ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After Certification: To the Hospital or Attending within 24 hours after death.

To the Funeral Director: After 5 ☐ Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident completely filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a To the Funeral C 1🕰 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

OH-2

State Registrar 29b. Signature and title

ersor

OCT 0 5 2007

no completed cause of death (Item 23a) (Type, Print)

29d. Date signed (Month, Day, Year)

		-	For State	State of N	Maryland		artment of F rtificate of		Mental Hy	~ ~	0.7	00100
	1.2		Registrar Decedent's Name (First, Middle)	lle, Last)			inoute of	Douth	2. Date of D		U/-	3. Time of Death
	hysici: /Medic	-	CLARENCE HEP	BURN LITTLE,	JR.				SEPTEM	BER 26	Year 2 00 7	0350 AMM
	Examin	4.00	4a. Facility Name (If not institution		er)		4b. City, Town, o		ath	4c. County	of Death	
			THE MEMORIAL 5. Social Security Number		Age (In yrs. la	ast hirthday)	EAS'		S. 8 Date of Bi	rth	TAL	BOT place (State or Foreign
	ineral rector		578-22-0218	1 X □M 2□F	82	Yrs.	Months Days	Hours Mir	JULY 2	rth ay, Yea <i>r</i>) , 1925	MARY	ntry)
ъ			Usual Residence of Decedent		140.00	<u> </u>						
Maryland	show ed at	۲	10a. State 10b. Count			, Town or Lo	cation				1	10d. Inside City Limits 1 Yes 2 No
å E S	r 28a-f show notified at	Director	MD 10e. Street and Number	TALBOT	<u> </u>	EASTON	10f. Zip Code			10g. Citizen of	What Cou	
. →	0 8	٥	3500 HUNTER (COURT				501		US		
	or Items 23a miner must	Funeral	11. Marital Status	12. Was Decede Armed Force	nt Ever in U.S	S. 13.	Was Decedent of H		Specify Yes or N		ce - Americ ck, White,	
0036 hours after	or it	by Fu	1 ☐ Never Married 2 ☐ Ma 3 🛣 Widowed 4 ☐ Divorce	rried 1X∑Yes 2[If Yes, Give	□ No	i i	1 ☐ Yes 2 X ☐ No	Specify:	,	Specia		ITE
-00 Phour	ical Exa			nt's Education	s: 143—1	16a. Dece	dent's Usual Occup	oation		16b. Kind of B		
21215-0036 d within 72 hours af giene.	an "ng Medi	Completed	(Specify only high Elementary/Secondary (0-12)	est grade completed) College (1-4c	or 5+)	(Give life.	kind of work done DO NOT use retire	during most of w d)	orking			•
21.	ed other than "n event, the Medi	Com	12	5±	,		OWNER/OPI					HOSPITAL
Maryland of 2 should be file the and Mental Hy	event, th	Be	17. Father's Name (First, Middle	•					ame (First, Middle	e, Maiden Surnai	me)	
Aarylance 2 should be to and Mental I	marke	၉ .	CLARENCE H. 19a. Informant's Name/Relation	<u>_</u>		19b Mailii	ng Address (Street		E HILL	her City or Town	State Zir	Code)
	2 :		MASON LITTLE/S								•	T, MD 21631
of Hea	r othe	1	20a. Method of Disposition			ace of Dispo	sition (Name of matory or other pla	i	Date	20c. Location		
Baltimore, permit. Pages 1 a	ant: If ury o		1 X Burial 2 □ Cremation 4 □ Donation 5 □ Other (JID RI	DGE CEME	TERY 10	/2/2007	BALTIMO	ORE,	MARYLAND
Baltir permit. P	Important; if it any injury or o once.		21. Signature of Funeral Service	Sland	l	F	2. Name and Addre ELLOWS, I 00 S. HAI	IELFENBE	IN & NEW T EASTON	NAM FUNI	ERAL :	HOME PA
/Me Exam	chysician and the burial-transit the burial-transit	dical Examiner	shock, or heart failure. Lis Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or b. END Due to (or NOW)	SER	ence of): GE & vence of): /AVE	LENAL MYOCA	DISEA VROIAL	SE INFAI	VLC TIOI	V	Interval Between Onset and Death
Box 6	red by the attending phy detached for use as the	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcor 1 □Live birth 4 □ Pregnan 9 □ Unknowr	2 ☐ Fetal t at time of de	death 3	⊒Ectopic pregnanc ⊒ Other <i>(specify)</i> _	у			ate of deliv	ery Day Year
ords, P.O	signed b be deta	y P	Part II. Other significant condi	tions contributing to death	n but not resu	lting in the u	nderlying cause giv	ven in Part I.	23e. Did	tobacco use con	tribute to t	he cause of death?
ord:	been sig should b								1	Yes 2 No	3 ☐ Prol	bably 4 ☐Unknown
e law	has le 2	Completed							24a. Was auto peri 1 Yes	s an 24b. opsy ormed? 2 No	prior to co	opsy findings available impletion of cause of
/ita	certificate rector, pag	Be	25. Was case referred to medic examiner?						eath (Check only			
or Vita	.≌ ≔ .	은	1 ☐ Yes 2 ♠ No 27. Manner of Death	Hospital: 1 Inpa		ER/Outpatier	IL 3 DOA		Home 5 Res			fy)
ISION (trending leath.	After th funeral	tion:	1 🗷 Natural 5 🗆 Pend		Day Year)	Injury	Wo	ryaτ rk?]Yes 2 □ No	280. Describe	how injury occu	rrea	
JIVISIO I or Attendi after death.	Director: I in by the	Certification:	3 Suicide 6 Could	I not be 28e. Place of	injury - At ho etc. (Specify	me, farm, sti	eet, factory, office			(Street and Num own, State)	ber or Run	al Route Number,
DIVISIC To the Hospital or Attendential of Attendential 24 hours after death	To the Funeral Direct completely filled in by	Medical Co	29a. Certifier (Check only one) 1 ✓ Certify 2 Medica	Ing Physician: To the be Il Examiner: On the basis and manner	s of examinat	wledge, deat ion and/or ir	h occurred at the to vestigation, in my	ime, date and pla opinion, death or	ce, and due to the	e cause(s) and m	nanner as s , and due t	stated. to the cause(s)
To the within	To the	Me	29b. Signature and title of certifi			-	29c. Licens	se number		29d. Date sign	ed (Month,	Day, Year)
			tolus	notses			Do	00594	87	04/	27/	07
			30. Name and address of perso									
			JOHN BOTSIS	M.D., 219 S	HARR	ISON S	ST., EAST	ON, MD	21601			
F	Sta Registr	te ar	31. Date filed (Month, Day, Yea,	8 2007	Barre o Original	1 2	books					

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day Vaar **Physician** P^{M} 3:55 SEPTEMBER 27 2007 OLIVE BRYAN LOWE /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner QUEEN ANNE'S 705 LOVE POINT ROAD STEVENSVILLE If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 □ M 2 🕱 F Yrs. 216-18-9790 84 JANUARY 12, 1923 MARYLAND Director Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10h County or 28a-f show r than "naturel", or items 23a or 28a-f ehov the Medical Examiner must be notified at 1 ☐ Yes 2 X No Directo MARYLAND OUEEN ANNE'S STEVENSVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 705 LOVE POINT ROAD UNITED STATES 21666 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puento Rican, etc.) 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: WHITE 1 ☐ Yes 2 🗓 No Specify: 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) **OWNER** NURSERY other 1 other treumatic event. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be fill ment of Health and Mental H lant: If item 27 is marked off CORA CARROLL NORMAN LEGG BRYAN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 320 MCLEOD LANE, STEVENSVILLE, MARYLAND 21666 HARRY C. LOWE, JR. / SON 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition OCTOBER 2 ŏ 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If eny injury or once. 2007 STEVENSVILLE, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) STEVENSVILLE CEMETERY 21. Signature of Funêral Service Licensee FELLOWS, HELFENBEIN AND NEWNAM FUNERAL HOME, P.A. 106 SHAMROCK ROAD, CHESTER, MARYLAND 21619 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** obstructive pulmonary years hronic everal /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine or Attending Physicien: The law requires that the death certificate be executed use as the burial-transit resulting in death) Last Due to (or as a consequence of): Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy Month Day Year signed by the at the detached for 4 Pregnant at time of death 5 Other (specify) Records, P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 □ No 3 □ Probably 4 □ Unknown 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 2 No 1 🗌 Yes Division of Vital To Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA this After thi funeral 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Certification; 1 Natural
2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No death. Director: / 6 Could not be 28e. Place of Injury At home, farm, street, factory, office building, etc. (Specify) 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours er
To the Funeral C To the Hospitel Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Stevensville, MiD lanie 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 0 Registrar 2007

amend line 15 per fdPlease Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. aaco hlth dept 10/01/07 dlystate of Maryland / Department of Health and Mental Hygieney Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** SEPTEMBER 24,2007 8:23 P M PROVIDENCIA LIU /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner ANNE ARUNDEL ANNE ARUNDEL MEDICAL CENTER ANNAPOLIS If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) MAY 6, 1937 9. Birthplace (State or Foreign Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Days 1 ☐ M 2 🖫 F PUERTO RICO 067-28-9325 70 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 No ral", or items 23a or 28a-f sh Examiner must be notifled Director MARYLAND ANNE ARUNDEL SEVERNA PARK 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code filed within 72 hours after death with 21146 UNITED STATES 275 BOWLINE ROAD Funeral 14 Bace - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black White etc. 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married HISPANIC Maryland 21215-0036 Specify: PUERTO RICAN 1 XYes 2 □ No þ an "natural", o Medical Exan 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) the OWN HOME HOMEMAKER 12 7 is marked other traumatic event, the 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 1 and 2 should be 1 Health and Mental LUISA SANTIAGO JUAN RODRIGUEZ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health a Important: If Item 27 is any Injury or other tra once. ELAINE ELIZABETH REED/DAUGHTER 275 BOWLINE ROAD, SEVERNA PARK, MARYLAND 21146 Baltimore, 20b Place of Disposition (Name of 20c. Location - City or Town, State Date 20a. Method of Disposition Pages 1 CHESAPEAKE CREMATION 1 ☐ Burial 2 XCremation 3 ☐ Removal from State SEPT. 4 □ Donation 5 □ Other (Specify) STEVENSVILLE, MARYLAND 2007 CENTER 22. Name and Address of Facility FFILOWS HELFENBEIN & NEWNAM CREMATION AND FUNERAL CARE, P.A., 814 BESIGATE ROAD, ANNAPOLIS, MARYLAND 21401 21. Signature of Funeral Service censee M00672 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Obstruetu Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner mars las and burial-tran physician Box 68760 pe Alexantanc Physician/Medical the IF FEMALE: for use a 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Dav 4□Pregnant at time of death 5 ☐ Other (specify) P.0. the 9☐ Unknown by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records. 2 Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an perform Belleten Diaseses 2□ No No Division or Vital 25. Was case referred to medical examiner? funeral director, 26. Place of Death Check onl one Be 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient 2 ER/Outpatient 3 DOA 1 🗀 Yes Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After t Hatural 5 Pending investigation 1 ☐ Yes 2 ☐ No Hospital or Attendi 24 hours after death. Funeral Director: A death. 2 ☐ Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 | Homicide 24 hours a ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

edical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. the 29d. Date signed (Month, Day, Year) 29c. License number 2 DOU43371 2001 MEDICAL and ad wass of reson who completed cause of reach (Item 23a) (Type, Print) JOSEPH-HERBERT. ANN APOCIS 400 gistrar's Signature 31. Date filed (Month, Day, Year) State SEP 2 7 2007 Registrar DHMH 17 Rev 1/2001

07-07850 Charles Lewis

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2007 33129

		I- For State Registrar		Certif	ficate of l	Death			Reg. No).	J. 001E
Physicia ledical Examin	n/ ier	Decedent's Name (First, Middle,L	Charles	Lewis	2. Date of Month Octobe		Year	3. Time of Death 0744 hrs			
		4a. Facility Name (if not institution, q 12924 Spruce Run Road				o. City, Town, or L Myersville	ocation of E	Death		c. County of De Frederick	ath
Funeral Director			Sex 7. Age X M 2 F	(In yrs. last	birthday) Yrs.	If Under 1 Year Months Days	If Under 2 Hours	Min	,	For	Birthplace (State or eign Country) Maryland
ore, MD 21215-0036 s I and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show any ner traumatic event, the Medical Examiner must be notified at once.	To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State	Run Road 12. Was Decedent Armed Forces? 1X Yes 2 1Yes, Give Vear or Dates: 7 only highest grade com College (1-4 or 5) 1 (Type, Print) 1 (Son) 2 Removal from Sta	10c. City, To Ever in U.S. 196 No 197 pleted) 16 5+)	5 13. Was If Yes 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	yersvill 10f. Zip Code 217 Decedent of Hisp s, specify Cuban, yes 2 X No s Usual Occupation st of working life. Mason Address (Street Spruce ion (Name of cem	73 anic Origin' Mexican, Pi specify: on (Give kin DO NOT us 8.Mother's I An An Numbe Run R ettery,	? (Specify Yes of uerto Rican, etc.) d of work done e retired) Name (First, Mic.) ary Fra. er or Rural Route d. Myer Date October 1, 2007	10g. Ci	tizen of What C U.S.A 14. Race - Am White, etc Specify: Kind of Busines Const n Surname) Nunamak City or Town, St e, Mary Location - City Smithsb	10d. Inside City Limits 1 Yes 2 X No Duntry? Perican Indian, Black, White SS/Industry ruction er ate, Zip Code) land 21773 or Town, State urg, Maryland
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Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the buri	Completed by	Diabetes mellitus				00 Di-	of Dochi, (C	24a.	Yes 2 Was an autopsy performed' Yes 2	24b. Were prior death	
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Division To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	edical C	29a. Certifier 1 Certifying Physone) 2 Medical Exami	sician: To the best of moner:On the basis of examend manner stated.	y knowiedge, mination and	, death occurre /or investigation	ed at the time, dat on, in my opinion,	te and place death occu	e, and due to the	cause(s) a	and manner as solace, and due to	stated. the cause(s)
F 3 F 3	Me	29b. Signature and title of certifier				29c. License				d. Date signed (ctober 9, 200	Month, Day, Year)
4		30. Name and address of person with Donna M. Vincenti, MD	no completed cause of d			Penn Street,	Baltimor	e. MD 2120	l 1		
· ·	ate rar	31. Date filed (Month, Day, Year)		r's Signature				5, MD 2 120		_	

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land ow		10a. State 10b. County	10c	. City, Town or L	ocation				10d. Inside City Limits
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re, Mary s 1 and 2 shou f Health and M item 27 is mar	1	Eva Marie Wright/PR		1	-	kson Ln., (5, 21p (3335)
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death cert a attendin d for use	clar	in the past 12 months?	1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time		□Ectopic p □ Other (sp			Month	Day Year
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Division of To the Hospital or Attending Ph within 24 hours effer death. To the Funeral Director: Affer th completely filled in by the funeral	Me	29b. Signature and title of certifier	- N-	1	29	c. License number		29d. Date signed (M	fonth, Day, Year)
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7(30. Name and address of person who co	empleted cause of death	(Item 23a) (Type	Print)	of Augana	Centra	6110 000	21/017
19	tate	30. Name and address of person who oce PC	ompleted cause of death	29 Ba	Print)	d Avenue	Centre	rile, mo.	21417

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Physician 1:35 PM 2007 Stanley Gerald McCumbers October /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town or Location of Death Examiner Harford Memorial Hospital Harford Havre de Grace If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1⊠M 2□F Months Days Hours Min Yrs. Director 235-20-4538 June 18,1922 West Virginia 85 Usual Residence of Decedent 10b County 10c. City. Town or Location 10d. Inside City Limits 10a State of 2 should be filed within 72 hours after deeth with the Marylar lith and Mental Hygiene.
27 is marked other then "naturel", or iteme 23a or 28a-f ehow traumatic event, the Medical Examinar must be notified. 1 ☐ Yes 2 No Director Aberdeen MD Harford 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21001 820 Lynn Lee Drive U.S.A. Completed by Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates: WWII Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: 3 St Widowed 4 □ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) General Motors Manufacturing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Anna G. Critchfield French McCumbers 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Deperiment of Heelth and Importent: If Item 27 is rr any injury or other traum 2002. Ella A. Del-Signore (Daughter) 4 Gyro Drive Baltimore, MD 21220 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 10/15/07 t ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Timonium, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Dulaney Valley Mem. Gdns 22. Name and Address of Facility
Tarring-Cargo Funeral Home, P.A.
Aberdeen, Maryland 21001-3399 21. Signature of Funeral Service Licenses 23a. Part 1. Enter the disease, or comblications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner ficile colitis ostridium S-quentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner ettending physicien and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day 5 Other (specify) certificate has been signed by the e rector, page 2 should be detached it 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? tear 2 No 1 🗌 Yes 2 🗷 (No 1 Tyes 20 : After this certifical funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Appatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 No 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) Certification: 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 ENatural 5 Pending efter death. Director: Aft 1 Yes 2 No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 | Homicide ō within 24 hours e To the Funeral I Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only To the I 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

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DHMH 17 Rev 1/2001

State Registrar 31. Date file (Month, Day,

2104R

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Year)

16

Thompson

32 Registrar's Signature

October 9, 2007

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician MAUCERI Month Day Cı LAWRENCE JOHN OCTOBER 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 6794 Accipiter Drive Frederick New Market 6. Sex 1X M 2 ☐ F Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** Months Days Hours Min. Director 63 024-32-1443 5-5-1944 Mass Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 X No Director MD Frederick New Market 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6794 Accipiter Drive 21774 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. within 72 hours after 1 ☐ Yes 2 X No If Yes, Give 1 ☐ Never Married 2 X Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify ò 3 ☐ Widowed 4 ☐ Divorced Year or Dates: White Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Senior Director of Marketing Communications permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked other any injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဂ Joseph Mauceri Helen DeFronzo 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sheila I. Mauceri Wife 6794 Accipiter Drive New Market MD 21774 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) St. Peter Cemetery 10/13/2007 Libertytown, MD 22. Name and Address of Facility Keeney & Basford P.A. F.H. 21. Signatura - Frineral Service Licensee M01176 106 East Church StreetFrederick, MD 21701 10 m (4) 23a. Part1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician (ARCINO HA of BLADDER 6 GEARS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine physician and s the burial-trans Due to (or as a consequence of): Box 68760. certificate be Physician/Medical as 1 attending IF FEMALE: use 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day 5 Other (specify) P.0. the 9 Unknown been signed by should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, à 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 WUnknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an has autopsy performed certificate 1□ Yes 2□ No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 Yes 2 No ဥ 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? al or Attending P s after death. al Director: After Certification: 5 ☐ Pending investigation 1 Natural (Month, Day Year) 1 ☐ Yes 2 ☐ No 2 Accident the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide To the Hospital o within 24 hours af To the Funeral D 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar OCT 1 6

32 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hospics of FAS SRICK COUNTY GEORGE 1. SMITH M.D. MADICAL GIRECTOR 516 TRAIL AVE FRADERICK AD

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October

FRG DERICK

		_	1 = For State Registrar	State of Maryla	nd / Depa	artment of He rtificate of D	ealth and M eath	Re	g. No.		
	Physicia /Medic		1. Decedent's Name (First, Middle, La Leo	John		Morawski		2. Date of Death September	36°, 2007 Yea		
	Examin		4a. Facility Name (If not institution, given Ft. Washington Hospital)			4b. City, Town, or L Ft. Washin			4c. County of Death Prince George's		
I	Funeral Director		5. Social Security Number 6. S 045–28–3929	7. Age (In yrs	s. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, April 2, 19	9. E 36 Co	Birthplace (State or Foreign Country) INNECTICUT	
	aryiand show	7	Usual Residence of Decedent 10a. State 10b. County Wassalawal Decimal County		City, Town or Lo					10d. Inside City Limits 1 □ Yes ※XX No	
	with the M sa or 28a-f Lee rotiffs	Funeral Directo	Maryland Prince Geo 10e. Street and Number 13816 Piscataway Driv		rt. Wasii	10f. Zip Code 20744		10	g. Citizen of What USA		
0000	permit. Pages 1 and 2 should be filed within 72 hours atter death with the Maryland Department of Heath and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Madical Examinar must be notified at once.	þ	11. Marital Status 1 Never Married 3 Widowed 4 Divorced	12. Was Decedent Ever in Amed Forces? Yell Yes 2 \(\text{No} \) No 1 If Yes, Give Year or Dates: 1963	060	Was Decedent of Hisp If Yes, specify Cuban, 1 ☐ Yes 2XXNo	panic Origin? (Sp Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - A Black, W Specify: Wh		
0-6171	within 72 ho lene. than "natur ire Medical	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0·12)	ducation ade completed) College (1-4or 5+)		dent's Usual Occupation work done dured to NOT use retired)		ing	6b. Kind of Busine Const	ss/Industry	
yiana z	uld be filed Aental Hygi rked other tic event, I	To Be C	17. Father's Name (First, Middle, Last Leo V. Morawi			1	8. Mother's Nam Anna	V. Kam	laiden Sumame) insky		
, mary	and 2 sho		19a. Informant's Name/Relationship (Carrien A. Alfaro-Mora	awski / Wife	13816	ing Address (Street an Piscataway I	Drive Ft.	Washington		e, <i>Zip C</i> ode) 20744	
Банттоге	Pages 1 ament of He ant: If Iten ury or oth		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 ★ '4 □ Donation 5 □ Other (Special Content of the Cont	MHemoval from State	Place of Dispo cemetery, cre . Agnes	osition (Name of matory or other place) Cemetery	10/06		coc. Location - City ranford, Co		
pair	permit. Departr Importr any in		21. Signatur uneral Service Lice	les		2. Name and Address 6160 Oxon Hil				. Home PA 20745	
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		Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consect. Due to (or as a consect.)							
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O. Box	that the death certific ed by the attending pi detached for use as t	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of preg 1 ☐ Live birth 2 ☐ Fe 4 ☐ Pregnant at time of 9 ☐ Unknown	tal death 3	□Ectopic pregnancy □ Other (s <i>pecify)</i>			23d. Date of Month	delivery Day Year	
ς. Σ	w requires that is been signed by should be deta	þ	Part II. Other significant conditions	contributing to death but not r	esulting in the t	underlying cause given	n in Part I.	23e. Did tob	1	e to the cause of death? Probably 4 Unknown	
Hec	The law ate has b page 2 st	Completed						24a. Was ar autops perform 1 ☐ Yes 2	y prior		
VITA	iician: certific rector,	o Be	25. Was case referred to medical examiner?	Hospital:	☐ ER/Outpatie	Other		h (Check only one	e) nce 6 □Other (S	Specify)	
DIVISION OF	ding After tune	Certification; T	27. Manner of Death 1. Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)		of 28c. Injury a Work?		28d. Describe ho	w injury occurred		
2	oltal or At urs after d oral Direct		4 Homicide determined	building, etc. (Spe	cify)			City or Town	, State)	r Rural Route Number,	
	To the Hospital or Attenwithin 24 hours after deatl To the Funeral Director: completely filled in by the	Medicai	29a. Certifier (Check only one) 2 Medical Exa	hysician: To the best of my k miner: On the basis of exami and manner stated.	nowledge, dea nation and/or in	th occurred at the time nvestigation, in my opin	nion, death occur	red at the time, da	ate and place, and one of the area of the	due to the cause(s)	
	T witl		1		1	119	151		9/30/	6	
20	+1		Frank MPG	completed cause of death (III	em 23a) (Type	Print)	1#103	77. NA	shing TO	MASONA	
	Sta Registi		QCT 0 2 2007	32. Registrar's Sig	Speck	7					

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** /Medical 4b. City, Town, or Location of Death County of Death 4a. Facility Name (If not institution, give street and number Examiner Mar yland ince HOSPITA Int If Under 1 Year | If Under 24 Hrs. 8. Date of Birth

(Month, Day, Year) 9. Birthplace (State or Country) 5. Social Security Number Age (In yrs. last birthday, **Funeral** Months Days Min. Hours 1□M 200 F 432-38-2567 1918 Director Usual Residence of Decedent s 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene.tem 27 is marked other than "natural", or items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at Yes 2□No Director Ma Mariboro 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number SA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 | Yes 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2D No Specify Specify: Completed by 3 Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) ivat item 27 is marked othe other traumatic event, 17, Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mitchel 10 ို 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Doughter Barbee Matthews Har 20772 Laura upper Mari boro ylan d 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Pages 1 permit. Pages Department of Important: If it any Injury or o 1 Surial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 10/5/07 Clinton Marvland esurrection 21. Signature of Funeral Service hicensee Funeral Home 22. Name and Address of Facility Forestville mozora ike Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Mutensur endo Vacencay disease or condition resulting in death) /Medical (or as a consequence of): Examiner mellities Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a conseque ce of): Examiner requires that the death certificate be executed burial-tra Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical as the attending p IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 18 months? Month Year 5 ☐ Other (specify) 4□Pregnant at time of death n signed by the a ld be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Tyes been : Were autopsy findings available prior to completion of cause of 24a. Was an page 2 has autops death? this certificate 1∐ Yes or Attending Physician: director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Medical Certification: To Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2ER/Outpatient 3□ D0A 1 Inpatient funeral 27. Marner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 ☐ Pending investigation within 24 hours after death.

To the Funeral Director: Aft completely filled in by the fu 1 Yes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Thurando 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

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31. Date filed (Month, Day, Yea OCT 0 2 2007

R. Miranda

upper Harlboro

7611 50.05borne Rd

32. Registrar's Signature

DHMH 17 Rev 1/2001

		State of Maryland / Department of Health a 1 - For State of Maryland / Department of Health a Certificate of Death		Hygiene Reg. 2007	33136							
Physic /Med		JEWELL MAZIQUE	2. Date o	Day Year	1 0005 M							
Exami	ner	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Takoma Park		4c. County of De								
Funera Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 1 Year Months Days Hours 93 Yrs.	24 Hrs. 8. Date o	f Birth 9. B	inhplace (State or Foreign							
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and 21215-0036 be filed within 72 hours after death with the Maryland ital Hygiene. In Hygiene. In a Maryland: or Items 23s or 28s-1 show event. Its Maryland Examinants must be notified at	b	1 1 Yes, Give Year or Dates:		Specify: B1	iite, etc.							
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Baltimo permit. Page Department of Important: if eny injury or once.		21. Signature of Funeral Service Licensee 22. Name and Address of Facility	ty McGuire	Funeral Serv	rice, Inc.							
		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as	· · · · · · · · · · · · · · · · · · ·		D.C. 20012 Approximate Interval Between							
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Di To the Hospitel or Within 24 hours after To the Funerel Dir completely filled in	ledical C	29a. Certifier (Check only one) 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date an examination and/or investigation, in my opinion, death occurred at the time, date and one)										
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5		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	CARROL	L AVENU	(E							
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DHMH 17 Rev 1/2001

			for State Registrar	State of i	viai yiai i		rtificate of			-	gierie Reg. No,	200	33137	
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	-		Usual Residence of Decedent							APILI.	ـ د د	7JZ FULA	.ru	
	arylar show dat	_	10a. State 10b. County		10c. City	, Town or Lo	cation					1	0d. Inside City Limits	
	he Ma 18a-f ptifie	Directo	Maryland Montg	omery	Po	tomac	7						1 ☐ Yes 2 🖾 No	
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9	ral",o	l by	3 Widowed 4 Divorced	If Yes, Give Year or Date	es:		1 ☐ Yes 2 🖾 No	Specif	y:			Specify: Whi	.ce	
S O	be filed within 72 hours after death with the Maryland ttal Hygiene. d other than "natural", or items 23a or 28a-f show event, the Medical Ecaminer must be notified at	Completed	15. Decedent's (Specify only highest	s Education grade completed)	cation 1/ e completed) I		dent's Usual Occu kind of work done DO NOT use retire	pation during me	ost of workir	ng	16b. Ki	nd of Business/Ind	dustry	
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an	d d d	To Be	Boris Shevcher	•				18. Mother's Name (First, Midd Anna Sierad			•			
Maryland 21215-0036	2 should be and Menta Is marked sumatic ev	F	19a. Informant's Name/Relationshi			19b. Mailir	ng Address (Street	and Num	ber or Rura	l Route Numb	er, City o	r Town, State, Zip	Code)	
	1 and 2 Health a iem 27 is		Ihor J. Masnyk	/Spouse		8614	Hidden H	i11 1	Lane,	Potoma	c, M	aryland	20854	
Baltimore,	permit. Pages 1 and 2 should Department of Health and Men Important: if Item 27 Is marke any injury or other traumatic once.		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation	2 Pomoval from Sta	20b. Pl	ace of Dispo	sition (Name of matory of other pla	ice)	D	ate	20c. Lo	ecation - City or To	wn, State	
Ĕ	Pages ment of ant: If Its lury or o		4 □ Donation 5 □ Other (Sp.		Örti	nodox	natory or other pla 's Ukrai Cemetery	nian	10/01	/2007	Some	rset, Ne	w Jersey	
ga T	permit. Depart Import any inj		21. Signature of Funeral Service L	i ensee	+	· H	Name and Addre	ess of Fac	ility FUNER	AL HOME	, IN	IC.		
	00 = 60		Maning A	V.e.com		11] به	1800 New	Hamp	shire	Ave, S	ilve	r Spring	, MD 20904	
7			23a. Part1. Enter the disease, or of shock, or heart failure. List of Immediate C e (Final	only one cause on each	h line.	. Do not ent	er the mode of dyl	ng, such a	as cardiac o	r respiratory a	rrest,		Approximate Interval Between Onset and Death	
	Physician /Medical		disease or condition resulting in death) a. ACUTE MYFLOGENOUS LEUKEMIA Due to (or as a consequence of):											
	Examiner			Due to (or	as a consequ	ence ot):								
	0.	Jer	Sequentially list conditions, if any list one tight cause. Enter Underlying Cause (Disease or injury											
	rtificate be executed ng physician and as the burial-transit	Examiner	that initiated events	с										
Ö,	e exe ian al urial-t		resulting in death) Last	Due to (or	as a consequ	ence of):								
68760,	cate b	l edical	·	d										
	ding p	/Me	IF FEMALE:	23c. If yes, outcor	me of pregna	nev								
Rox	death cerl e attendin ed for use	Physician/	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth	n 2 ∐ Fetal tat time of de	death 3	Ectopic pregnanc Other (specify)	y			1	23d. Date of delive Month	ery Day Year	
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ď.	ee ≇	by Pt	Part II. Other significant condition	s contributing to death	h but not resu	Iting in the u	nderlying cause giv	ven in Par	t I.	23e. Did to	obacco u	se contribute to th	ne cause of death?	
Records,	w requires been sign should be									1 🗆 🕆	res 2	No 3 □ Prob	ably 4 □Unknown	
ပ္တ	law re as bee	Completed								24a. Was	an	24b. Were auto	psy findings available	
	ا دو غو	E O					-	-		autor perfo 1□ Yes	rmed? 2	death?	npletion of cause of 2 □ No	
Vita	sician: The certificate rector, pag	Be C	25. Was case referred to medical examiner?						ce of Death	Check onl				
<u>o</u>	Attending Physician: r death. ector: After this certific by the funeral director.	70	1 ☐ Yes 2 📉 No	Hospital: 1 X Inpa		ER/Outpatien	N OLIDON		Nursing Hor	ne 5 ☐ Resid	dence	6 □Other (Specify	v)	
Ž	ding F		27. Manner of Death 1 XNatural 5 ☐ Pending		njury Day Year)	28b. Time of Injury	Wor			28d. Describe I	now injur	y occurred		
<u> </u>	ttend death stor:	cat	2 Accident investiga 3 Suicide 6 Could no	ot be 280 Place of	inium. At hor	mo form etr]Yes 2[Of Leasting (C44	al Africa base and Driver	(Davida Aliverta e	
									'	City or Tov	vn, State	d Number or Rura)	i noute Number,	
	To the Hospital or A within 24 hours after To the Funeral Directional Completely filled in by		29a. Certifier 1 X Certifying	Physician: To the be	est of my knov	vledge, deatl	n occurred at the ti	ime, date	and place, a	and due to the	cause(s)	and manner as st	tated.	
	P S S P S S P S S P S P S P S P S P S P	Medical	(Check only 2 ☐ Medical E	xaminer: On the basis and manner	s of examinat	ion and/or in	vestigation, in my	opinion, d	eath occurr	ed at the time,	date and	d place, and due to	the cause(s)	
	To the within To the compl	ž	29b. Signature and title of certifier	^ -	0	Λ.	29c. Licens	se number	r		29d. Dat	te signed (Month,	Day, Year)	
2	20		> yo de	New	1	70	0200)2 <u>3</u> 97	A (IN		C	1/28/	07	
			30. Name and address of pers n w	ho completed cause of	feath (Item	23a) (Type,				NAVAL	MED]	I CENT	ER	

State Registrar ROBERT J. CARPENTER LCDR MC

31. Date filed (Month, Day, Year)

OCT 0 2 2007

32 degistrar's Signat

LCDR MC USN
32 Jegistrar's Signature

BETHESDA MD 20889-5600

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 10'. 40 PM MIKUS 00 04 MAXINE 07 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 9. Birthplace (Country) Chestnut Gr Under 1 Year | If Under 4202 5. Social Security Number 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday, **Funeral** Days Hours Months Min. 1 ☐ M 2 🔀 F Director 214-16-0850 86 DEC. 1920 MARYLAND Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County show Examiner must be notified at 1 ☐ Yes 2 X No Director MARYLAND WASHINGTON KEEDYSVILLE 28a-f 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ö 21756 4202 CHESTNUT GROVE ROAD U.S.A. Items 23a Funeral Pages 1 and 2 should be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 14. Race - American Indian, Black, White, etc. 1 □ Never Married 2 □ Married "natural", or Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify þ Specify: 3 ☐ Widowed 4 X Divorced WHITE Year or Dates: er than "natura , the Medical E Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other traumatic event, the Many Injury or other traumatic event, the Mones. WAITRESS RESTAURANT 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be CARRIE L. NORRIS GEORGE W. ABBOTT ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4206 CHESTNUT GROVE ROAD, KEEDSYVILLE, MARYLAND ANTHONY W. MIKUS/SON Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 5 Other (Specify) 10/09/2007 Rohrersville, Maryland 4 □ Dopation PLEASANT VIEW CEM. 22. Name and Address of Facility Funeral Selvice Licensee 21. Signature of 7606 Old National Pike Paul M. Dean BAST FUNERAL HOME Boonsboro, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** 1 week Tena disease or condition resulting in death) /Medical Due to (or as a consequence of): discus Examiner nronic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine spital or Attending Physician: The law requires that the death certificate be executed ours after death.

leral Director: After this certificate has been signed by the attending physician and filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Completed by 2 No 1 TYes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1□ Yes 25. Was case referred to medical 26. Place of Death (Check only one Be examiner's Other: 4 Nursing Home SKResidence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3□ DOA Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Injury 5 ☐ Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral I certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 1) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year)

WH-6

State Registrar Hayerstown

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

13424

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31. Date filed (Month, Day, Year)

Pennsy

32. Registrar's signature

			1 - For State Registrar	State of Marylan	•			ealth a D <i>eath</i>	ınd Mer	, ,	iene eg. No.2	7 33139		
	Physici	an	Decedent's Name (First, Middle, Last)	Μ						Date of Deat Month OPT	28 2007	3. Time of Death		
	/Medic	al	William Preston 4a. Facility Name (If not institution, give s							ерт	4c. County of De	15:02P M		
	Examin	er	Washington Count			10. 01.)		erstov				on County		
I	Funeral Director		5. Social Security Number 6. Sex 217–42–9960 Usual Residence of Decedent	M 2□ F 7. Age (In yrs. 62		If Unde Months	Days	If Under 2 Hours	8. Min.	Date of Birth (Month, Day, OV 18	9. Bi	irthplace (State or Foreign Sountry) aryland		
	yland Iow		10a. State 10b. County		y, Town or Lo							10d. Inside City Limits		
	e Man	ctor	Maryland Washington Hagerstown									14 Yes 2 □ No		
	th with th	al Director	10e. Street and Number 436 North Mulberr	y Street		10f. Z	p Code	21740	0	0g. Citizen of What C				
036 urs after deat oil, or items 2	be filed within 72 hours after death with the Maryland tal Hygiene d other then "nature!', or items 23a or 28a-f ehow event, the Medical Exartal ar mush be molified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	Was Decedent Ever in U. Armed Forces? □ Yes 2 □ No If Yes, Give Year or Dates:	1	Was Dece If Yes, spe 1 Yes	**	spanic Orig n, Mexican, Specify:	in? (Specify , Puerto Rica	Yes or No- an, etc.)	14. Race - Arr Black, Wh Specify: W			
<u>.</u>	"natu	etec	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of work								16b. Kind of Busines	s/industry		
7.	withir iene. then	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)			ng As				Nove1t	y Company		
פ		BeC	17. Father's Name (First, Middle, Last)		1				r's Name (F	irst, Middle, M	Maiden Sumame)			
<u>Z</u>		To	Preston Raleigh								eth Miles			
Maryland 21215-0036	12 Tra		19a. Informant's Name/Relationship (Typ			-					City or Town, State,	22,10		
	1 an Heel Heel ther		Patricia A. Moats – wife 436 North Mulberry Street Hauerstown 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or cemetery, crematory or other place)											
Ë	00		1 X Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	moval from State	emete:	.	Oct 1			wn Maryland				
Baltimore,	permit. Page Depertment Important: if eny injury o		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Douglas											
11	207.9		Kaittin Jaffa	non								yland 21742		
,	Physician /Medical		23a. Part1. Enter the disease, or conhplic shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	cations that caused the death e cause on each line. Cornary Due to (or as a conseq	Arte		,		cardiac or re	espiratory arre	951,	Approximate Interval Between Onset and Death		
	Examiner		Congostive Heart Failure											
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õ	rtificate ng phys as the	Medi	IS STANKE.											
O. BOX	w requires that the death certifics been signed by the attending pt should be detached for use as t	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify)							23d. Date of do Month	elivery Day Year		
ດ, ກຸ	s that t ned by e deta	by Ph	Part II. Other significant conditions conf	ributing to death but not res	ulting in the u	nderlying	cause give	n in Part I.		23e. Did tob	acco use contribute	to the cause of death?		
SDC	en sig	ed b	Renal Transpla	nt						1.2Ye	es 2□No 3□F	Probably 4 Unknown		
I Kecord	The law ete has b page 2 si	Completed							-	24a. Was an autops perform	y prior to			
VItal	Physician: Th this certificete ral director, pag	Be	25. Was case referred to medical examiner?	nenital:	/		0.0			heck only on				
5	Phys this al dii	2	1 ☐ Yes 2 ☑ No ☐ 1		ER/Outpatien 28b. Time of		OA Othe	at 4 □ Nurs		5 Residence 6 Other (Specify) Describe how injury occurred				
0	Attending Ph r death. ector: Alter thi by the funeral	ation	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	Injury	м	28c. Injury Work 1 🔲 Y	:? ∕es 2 ⊡ N	ł	. Boodings in				
DIVISION	To the Hospital or Attendi within 24 hours efter death. To the Funerel Director: A completely filled in by the fu	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					28f.	28f. Location (Street and Number or Rural Route Number, City or Town, State)				
	he Hospi in 24 hour he Funer pletely fills	edical	29a. Certifier 1 Certifying Phys (Check only one) 2 Medical Examin	p Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date a and manner stated.								as stated. ue to the cause(s)		
	with To t	Σ	29b. Signature and title of certifier	7. 11. 21		29	c. License			25	9d. Date signed (Mor			
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51	1-5		30. Name and address of person who cor				710							
Ĺ	Sta		368 Mill Street 31. Date filed (Month, Day, Year)	32. Registrar's Signa	ture	1 41	/4U							
	Registr	ar	OCT 0 3 20	U/ APROXIM	11 4	STATE	1							

DHMH 17 Rev 1/2001

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State

Registrar

MAZAAK

31. Date filed (Month, Day, Year)

OCT 0 2 2007

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07-07532 Richard Mohr Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2007 33141

			For State Certification		Reg. No. 2. Date of Death 3. Time of Death									
Physic	cian		gistrar Decedent's Name (First, Middle,Last)	2. Date of Month	Death	, 2007 Year		1745 hrs						
Exar			RICHARD TODD MOHR						4c. County of					
		4 <i>a</i>	. Facility Name (if not institution, give street and number)	4	b. City, Town, or L	ocation of E	Death				OT INV			
			University Hospital		Baltimore						CITY			
F		5.	Social Security Number 6. Sex 7. Age (In yrs. last	t birthday)	If Under 1 Year	If Under 2			M/DD/YYYY)					
Funera Directo				Yrs.	Months Days	Hours	Min. 01/	12/1	974	Countr	y) MARYLAND			
Directo	1		214-84-4864 1X M 2 F 33	113.	<u> </u>									
			sual Residence of Decedent	own or Locati	on						d. Inside City Limits			
any	- 1	10	Ja. State			1	X Yes 2 No							
pu wou s	3	<u> </u>	MD WORCESTER BE	RLIN				100	Citizen of Wh	at Country	?			
uryla 3a-f	to t	5 1	De. Street and Number		10f. Zip Code			109.	USA	at occinity				
e Ma or 28	jed .	Director	27 TAIL OF THE FOX DRIVE		21811									
th th 23a	noti		1. Marital Status 12. Was Decedent Ever in U.S	. 13. Wa	s Decedent of His	panic Origin	? (Specify Yes	or No-	14. Race White		n Indian, Black,			
ih wi	t be		V Never Married 2 Married Armed Forces?	If Y	es, specify Cuban	, Mexican, F	Puerto Rican, et	5.)	VVIIILE					
deat or it	mns	וַבּ	Yes 2 X NO	1	Yes 2X No	specify:			Specify:	WH	ITE			
after	ine		or Dates:	16a Deceder	ot's I Isual Occupat	ion (Give ki	nd of work done	16	b. Kind of Bu	siness/ind	ustry			
ours	Kam	Completed by	15, Decedent's Education (opean) and	during m	nost of working life.	. DO NOT u	se retired)							
72 h	<u>E</u>	翼口	Elementary/Secondary (0-12) College (1-4 or 5+)	CEI F.	-EMPLOYED	OWNE	CR.		MARINE	CONS	TRUCTION			
thin thin	edic	유	12 3	SELE	- LITT HOTEL	40 14-46-000	Name (First, M	ddle Mai	den Surname)				
od wi	e N	٦٥	7. Father's Name (First, Middle, Last)			16.Moulei S	MONA J	EAN	MOORE	,				
215-0036 be filed within 7 mal Hygiene. rked other than	nt,	Be l	RICHARD L. MOHR							in State 7	in Code)			
D 21215-0036 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Tis marked other than "natural", or items 23a or 28a-f she	ě	0	19a. Informant's Name/Relationship (Type, Print)	19b. Mailin	ng Address (Stree	et and Numb	oer or Rural Rou	te Numbe Turk	VIII.E.	MD 2	21617			
MD of 2 show alth and 27 is	ia di	-	MONA JEAN ANDERSON/MOTHER					MIKE	EVILLE, MD 21617 20c. Location - City or Town, State					
e, MI I and 2 Health a	Lant		20b. F	lace of Dispo	sition (Name of ce	metery,	Date							
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland perment. Pages I and 2 should be filed within 72 hours after death with the Maryland benorian: I filem 27 is marked other than "natural", or items 23a or 28a-f show	hert	- 1	1 Burial 2 X Cremation 3 Removal from State CHF	SAREAK	E CREMAT	LON	9-29-20	107	STEVEN	PATFI	E, ED			
Page Fent	r of	- 1	4 Donation 5 Other Specify:											
mit.		Г	21. Signature of Funeral Service Licensee	FE	LLOWS, HE	LFENB	EIN & N	WNAM	FUNE	MD 2	OME, P.A.			
6 P P 6	<u> </u>	- L	al 4. To Mar	1/0	0 6 110	P.D.LA 4	CI LP	4 I K I		1110 2	Approximate Interval			
sic	ian	†	23a. Part I. Enter the disease, or complications that caused the death.	Do not enter	the mode of dying	, such as ca	ardiac or respira	lory arres	i, SHOCK, OF TH	Juit	Between Onset and			
√ledi			a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Death											
Exami	ner		mmediate Cause (Final disease a. Head and Neck Injuries or condition resulting in death) Due to (or as a consequence of):											
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		Ë.	cause. Enter Underlying Cause											
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60, ate be e	sicia	ed		nancy					23d. Date	of delivery				
76 ficate	g phy		23b. Was decedent pregnant in the	2	Fetal death 3	Ectopi	c pregnancy		Month	nth Day Year				
. Sertii 6	nding se as	<u>ā</u> .	past 12 months? 4 Pregnant at time of d		Other (Specify)									
Box 687 death certifie	e attending for use as t	sic	1 Yes 2 No 9 Unknown 9 Unknown			7507-51-0					(11-0			
De de	ned by the a detached fo	Physician	Part II. Other significant conditions contributing to death but not	resulting in th	e underlying cause	e given in Pa					the cause of death?			
P.O	ed b		, are in our significant					Yes	2 🗸 No	3 Prob	ably 4 Unknown			
ies i	has been signe 2 should be d	Completed by					2	la. Was a	an 24b. Were autopsy findings available					
Par me	houl	let l						autops perfor		prior to or death?	completion of cause of			
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₽e ≟	ficate pag	ပြ			26.Pla	ace of Death	(Check only or	e)						
<u> </u>	certif	å	25. Was case referred to medical examiner?	ER/Outpati		Other-	Nursing Hom		Residence (6 Othe	r:			
Division of Vital Records, real or Attending Physician: The law requir is after death.	this certificate h	l 0	1 ✓ Yes 2 No Impatient 2		-	njury at Wor	4.0 204 1	occribe b	ow injury occ	curred				
of F	After	':-	27. Manner of Death 28a. Date of Injury (Month, Day Yeer) 1 Natural 5 Paneling Sep 25, 2007	28b. Time 0250 hrs		Yes 2	Drive	r auto t	ixed object	ct collision	on during police			
D. adi	he fu	[₫	5 Ferfallig	1	1 '-		pursi	uit			red Poute Number City			
Sic Atte	recto	ica	2 Accident Investigation 28e. Place of Injury - At	home, farm, s	street, factory, offic	e building,	etc. 28f. L	ocation (S	street and Nu tate)	moer or Ri	ural Route Number, City			
j∨j l or safte	27. Manner of Death 1 Natural 5 Pending Investigation 28a. Date of Injury Sep 250 hrs 1 Yes 2 No 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? Deriver auto fixed of pursuit 28c. Injury at Work? 1 Yes 2 No 28c. Injury at Work? 1 Yes 2 No 28c. Injury at Work? 28c. Injury at Work? 28d. Location (Street are of Town, State) Ocean Parkway, Oce of Town, State) 28c. Place of Injury - At home, farm, street, factory, office building, etc. 28c. Injury at Work? 28c. Location (Street at Action), of Continuing at Work? 28c. Location (Street at Action), of Continuing at W									Pine , MD				
Spits	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as										ted.			
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.	e Fu	ca	29a. Certifier 1 Certifying Physician: To the best of my knowle (Check only one) 2 Medical Examiner: On the basis of examination	and/or invest	tigation, in my opin	nion, death o	occurred at the t	me, date	and place, ar	nd due to t	ne cause(s)			
it it	ompl	Medical	and marrier stated.			ense numbe			29d. Date s	signed (Me	onth, Day, Year)			
	. - 0	Įž	29b. Signature and title of certifier						Septem					
			Marchianell MD		0.	C.M.E.			Coptoni					
SO			30. Name and address of person who completed cause of death (Ite	em 23a)										
12	,		Melissa Brassell, MD Assistant Medical Exan	niner 11	1 Penn Street	t, Baltimo	ore, MD 212	01						
100					1 0					-				
		State stra	nct n 1 2007 Marie	Jr.	Good !									

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State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

WILLIAM D.

29b. Signature and title

M.D. 122 SPEER ROAD, SUITE 5, CHESTERTOWN, MARYLAND 21620 32. Registrar's Signature

TRAINOR,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DAN

certifier

29c. License number

26789

29d. Date signed (Month, Day, Year)

			For State		State of M	laryland	/ Depart	ment o	f Healt	h and M	lental H	ygiene	200	7 331	43		
			Registrar	(First Middle Las			Certi	ficate d	or Dea	tn	2. Date of D	Reg. No.		3. Time of Dea	th		
	Physicia		Sara i Millor								A Month	Day		0610	М		
03	/Medic																
			Memorial					Eas	-				Talbo7	_			
	Funeral Director		5. Social Security No. 221–32–64	155	ex 7. A □ M 2 3 F	ge (In yrs. las		f Under 1 Ye Ionths Da		der 24 Hrs. Irs Min.	8. Date of E (Month, L Dec. 1	Day, Year)	- Co	thplace (State or For buntry) elaware	eign		
	land land		Usual Residence of 10a. State	10b. County		10c. City,	Town or Locat	ion						10d. Inside City Lir	mits		
	Mary r-f sho fied a	tor	DE	Suss	ex	Lau	rel							1 □ Yes 2 🔀	No		
	th the or 28¢ e noti	Jirec	10e. Street and Nun	nber				10f. Zip Coo	le			10g. Citiz	zen of What Co	ountry?			
	ath w	ral	33395 SI	ockley R				1995				U.S					
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral Director	11. Marital Status 1 ☐ Never Marri 3 ☐ Widowed		12. Was Deceden Armed Forces 1 □ Yes 2 X If Yes, Give Year or Dates:	?] No	If Y	s Decedent es, specify (Yes 2 X	Cuban, Mex	kican, Puerto	ecify Yes or N Rican, etc.)		14. Race - Ame Black, Whit Specify:				
21215-0036	rithin 72 hu ne. han "natu Medical	Completed	(Speci	15. Decedent's Ed ify only highest gra ndary (0-12)	lucation de completed) College (1-4or			d of work do NOT use re	nne during i tired)	most of work	ing	Ι.	nd of Business	/Industry			
7 7 7 7 7 7 7	iled w Hygiel ther tl nt, th	S	17. Father's Name (First Middle Last)	7		Н.	omemal		lother's Nam	e (First, Midd		Home				
and le	d be f ental I ked of c eve	To Be		Cruther					10.11		•		,	Inknown)			
Maryland	shoul and M s marl umati	۴	19a. Informant's Na				19b. Mailing	Address (Str	reet and Nu				Town, State,	<u>-</u>			
	and 2 ealth a n 27 is			_	s, Sr. (F						aurel,	DE	19956				
Sara altimore	ges 1 t of Hi If iter or oth		20a. Method of Disp 1 Burial 2		Removal from State	e cer	ice of Dispositi metery, crema	ory or other	place)	1	Date	20c. Lo	cation - City or	Town, State			
Saci	t. Partmen rtmen rtant: njury			5 Other (Specify	·	Степ	atory				-2007	Del	mar, De	laware			
Bal	permii Depar Impor any Ir once.		21. Signature of Fu	Shor	t-Jen	rell	Sh 13	E. G1	neral cove	l Home St. D	elmar,	_	19940				
					plications that cause one cause on each	ed the death. line.	Do not enter	he mode of	dying, suc	h as cardiac	or respiratory	arrest,		Approximate Interval Between Onset and Deat			
	Physician /Medical		Immediate Cause (disease or condition resulting in death)	Final 1	a	SYCHS		nee	1					Syean	5		
	Examiner				Due to (or a	s a conseque	ence of):							1			
	* **	ner	Sequentially list con if any, leading to im cause. Enter Unde	nditions, mediate	b. Due to (or a	s a conseque	ence of):							<u></u>			
	cate be executed physician and the burial-transit	Examiner	that initiated events	injury	C												
60,	be execian a		resulting in death) L	dst	Due to (or a	s a conseque	ence of):										
68760,	icate l physi	dical			_d												
Box (leath certific attending p	Physician/Me	IF FEMALE: 23b. Was decedent in the past 12	months?	23c. If yes, outcom 1□Live birth 4□Pregnant	2 🗌 Fetal o	death 3□E	ctopic pregn				2	23d. Date of de Month	livery Day Year			
P.O.	that the de led by the a detached i	ysi	1 Yes 2 9 Unknown	4No	9□Unknown			anor topoon	//								
Division or Vital Records, P	Attending Physician: The law requires that the death certifier death. ector: After this certificate has been signed by the attending by the funeral director, page 2 should be detached for use as	by	Part II. Other signif	icant conditions o	ontributing to death	but not result	ting in the unde	rlying cause	given in P	art I.		A	,	o the cause of death robably 4 □Unkn			
ဝင္တ	e law re has bee je 2 sho	Completed									24a. W		24b. Were a	utopsy findings avail	able		
Ä	The ate his page	Com										topsy rformed? 2 No	death?	completion of cause 2 □ No	r OI		
Vita	certificate ector, pag	Be	25. Was case reference examiner?		Hoonitals .					lace of Dear	th (Check onl	v one)					
o	iding Physician: h. : After this certifica : funeral director, i	<u>۲</u>	1 Yes 2 2		Hospital: Inpai		R/Outpatient 28b. Time of	3□ DOA		Nursing H	ome 5 ☐ Re 28d. Describ		6 ☐Other (Spe	ecify)			
on	rding th. : After e fune	tion	Natural 2 Accident	5 Pending investigation	(Month, D	Day Year)	Injury		Injury at Work? 1 □ Yes	2□No	20d. Describ	e now injur	y occurred				
VİSİ	Attend r death. ector: / by the f	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined		njury - At hom	ne, farm, stree	, factory, of	fice		28f. Location	(Street and	d Number or Fi	ural Route Number,			
Ö	i Diffi o	Cert	4 Homicide		building, t	etc. (Specify)					City of I	own, state,					
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical	29a. Certifier (Check only one)		nysician: To the bes miner: On the basis and manners	of examination											
	To t To t	Σ	29b. Signature and	title of certifier	1	0 -	1	29c. Lie	cense numl	ber		29d. Dat	te signed (Mon	th, Day, Year)			
	. 1		,	May	pre	Der	Close	2 .	047	232		19/	24/	2007			
(FMA		30. Name and addr	ess of person who	completed cause of	death (Item 2	23a) (Type, Pr	nt)	, 1	Sha	., <	,	101 6	el and	711		
	Sta	ate	31. Date filed (Mon	SEP 2 7	32. Regis	strar's Signatu	ire	TUEF	urde	JYE	T 3	11+2	14 6	25tm, (11)0	× 16,06		
	Registi			SEP & 7	2007	PARA A	H A	met !									

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Year **Physician** Wilma Lee Mills octobe. /Medical 4a, Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington Hagerstown Washington County Hospital If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) May 21, 19: Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Months Hours Yrs 1951 220-58-2839 56 Director Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ral", or items 23a or 28a-f show Examiner must be notified at 1 ☑ Yes 2 ☐ No Director Maryland Funkstown Washington 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number death with 21734 U.S.A. *30 West Chestnut Street Lot#8* Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married altimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify Specify. þ 3 Widowed 4 Divorced White "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Home Homemaker 11 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mental Laura V. Law Robert L. West 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 30 W. Chestnut St. Lot#8 Funkstown, Maryland 21734 item 27 i Kelly L. Moser (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Department of P Important: If ite any Injury or ot once. 1 ☑ Burial 2 □ Cremation 3 □ Removal from State October Ringgold Cemetery Ringgold, Maryland 4 Donation 5 ☐ Other (Specify) 2007 21. Signature of Funeral Service Licensee 22. Name and Address of Facility J.L. Davis Funeral Home 12525 Bradbury Ave. Smithsburg, Maryland 21783 MIS 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Periton Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury Examiner tage The law requires that the death certificate be executed burial-transi that initiated events and resulting in death) Last Due to (or as a consequence physician Physician/Medical the as IF FEMALE: use 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 mont 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 9☐Unknown 5 Other (specify) signed by the a 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Hiknown Completed 24b. Were autopsy findings available prior to completion of cause of death? page 2 s performed certificate 1 Yes 21 No 20 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 20 KO 2 ER/Outpatient 3 DOA 1 ☐ Yes 1 Inpatient မ 28a. Date of Injury (Month, Day 27. Manner of Death 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred 14 Natural

Division or Vital Records, P.O. Box 68760, Hospital or Attending Physician: funeral director After safter deural Director: Aff filled in by within 24 hours a

To the Funeral I

completely filled

Certification: 2 Accident 3 Suicide 4 ☐ Homicide 29a. Certifier Medical

5 Pending investigation

6 ☐ Could not be determined

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State) Tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

HAGERSTOWN,

lutani 29b. Signature and title of certifier

and manner stated.

D58853

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CHOTANI HABIB 31. Date filed (Month, Day, Year) 0CT 1 6 2007 16

ANTIETAM ST, E 32. Registrar's Signature

State

		Registrar	ate of Maryland	Cer	tificate of L	Death	Reg	2 U U /	33145
Physicia	an	1. Decedent's Name (First, Middle, Last) Sandra Gail martin					2. Date of Death Month	Day Year	
/Medic Examin		4a. Facility Name (If not institution, give street	and number)		4b. City, Town, or	Location of Death	B 9-27-20	007 4c. County of De	B;35 a M
Lxamiii		9901 savage road			OCEAN CI			WORCESTE	R CO
Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. las	***	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,) 05-28-58		irthplace (State or Foreign Country)
Director		216-72-2165 Usual Residence of Decedent	49	Yrs.			05-28-58		Vā
yland		10a. State 10b. County	10c. City,	Town or Loc	cation				10d. Inside City Limits
Ba-fa	Director	MD WORCESTER	OCEA	N CITY	Υ				1 ☐ Yes 2√CNo
with th	Dire	10e. Street and Number			10f. Zip Code		109	g. Citizen of What (Country?
leath y	Funerai	9901 SAVAGE ROAD 11. Marital Status 12. W	/as Decedent Ever in U.S.	13. V	21842 Vas Decedent of Hi	ispanic Origin? (Sr	US.		nerican Indian,
re, will yiellid ZIZISOOSO s I and 2 should be filed within 72 hours after death with the Maryland I Health and Mealler Hygens. I Health and Mealler Hygens the marked other than "natural", or Items 23a or 28a-f ahow other traumatic event, tra Mealler Exaction must be notified at	by Fun	1 □ Never Married 2 □ Married 1	med Forces? □Yes 2□No Yes, GiveXX ear or Dates:	lf	Yes, specify Cuba ☐ Yes 2 No	Specify:	Rican, etc.)	Black, Wh	ite, etc.
in 72 hou	Completed	15. Decedent's Education (Specify only highest grade con	npleted)	(GIVO I	ent's Usual Occupa kind of work done o OO NOT use retired	during most of wor	king	Sb. Kind of Busines	s/Industry
d with giene.	mo	Elementary/Secondary (0-12) C	ollege (1-4or 5+)	BARTEN	VDER		F	OOD SERVI	CE
yiding 2.12 buid be filed with Mental Hygiene. arked other the	Be (17. Father's Name (First, Middle, Last)					ne (First, Middle, Ma		
should be nd Mental marked c	2	WILMER OSBOURNE 19a. Informant's Name/Relationship (Type, P	lafaet)	405 14-75-		BETTY JOI			
and 2 sho saith and n 27 is m							ral Route Number, (-	, ZIP Code)
iges 1 and 27 in of Health if item 27 in or other tri		20a. Method of Disposition	20b. Pla	ce of Dispos	sition (Name of natory or other place			Oc. Location - City of	or Town, State
nt. Pages intment of I rent: If its		1 ☐ Burial 2 ☐ Gremation 3 ☐ Remove 4 ☐ Donation 5 ☐ Other (Specify)	ai from State		OF DELMA	1	28-07 D	ELMAR, DE	L.
Dealtimo		21. Signature of Function Service Licensee	7	22.	Name and Addres	s of Facility	Ø\$	7 wich	115 ct
4050		23a Part 1 Fater the disays of complication	ns that caused the death				AL HOMESA		MD Approximate
Physician		23a. Part1. Enter the disease) or complication shock, or hear failure. List only one call immediate Cause (Final disease or condition		ailure		y, such as cardiac	or respiratory arres	it,	Interval Between Onset and Death
/Medical Examiner		resulting in death)	Due to (or as a conseque Metastatic	Calo	n Can	Cay			
uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that indiated events	Due to (or as a conseque	nce of).					
oo (oo) icate be executed physician and s the burial-transit	I Exa	resulting in death) Last	Due to (or as a conseque	nce of):					
	dical	d							
vequires that the death certific been signed by the attending pandle be detached for use as	Physician/Me	in the past 12 months?	yes, outcome of pregnanc □Live birth 2 □ Fetal d □ Pregnant at time of dea □ Unknown	eath 3 🗌	Ectopic pregnancy Other (specify)			23d. Date of d Month	elivery Day Year
that the poly detach	by Ph	Part II. Other significant conditions contribu	ting to death but not result	ing in the un	iderlying cause give	en in Part I.	23e. Did toba	cco use contribute	to the cause of death?
w requires to been signer should be							1 🗀 Yes	2 □ No 3 □ I	Probably 4 Dinknown
25 25 0	Completed						24a. Was an autopsy performe	prior to death?	autopsy findings available completion of cause of
VICIAN: ician: certifica ector, p	Be	25. Was case referred to medical examiner?	at		100		th (Check only one))	
Physic ruthis or	1: To	1 ☐ Yes 2 ☐ Mo Hospit	1 Inpatient 2 El	P/Outpatient 8b. Time of	3 □ DOA Othe	^{91:} 4 ☐ Nursing H	ome 5 Aesiden 28d. Describe how		eacify)
sion teath. tor: Afte the fune	atlon	1 Natural 5 Pending 2 Accident Investigation	(Month, Day Year)	Injury	28c. Injury Work M 1 🗀 🗅	(? Yes 2 □ No	Zod. Doscillo ilon	injury occurred	
or Atternation of Atternation of Director in by the	Certification:	3 Suicide 6 Could not be	e. Place of Injury - At hom building, etc. (Specify)	e, farm, stre	eet, factory, office		28f. Location (Stre City or Town,	eet and Number or I State)	Rural Route Number,
D	9								
ne Hospital 24 hours te Funeral		(Check only 2 Medical Examiner: (n: To the best of my knowl On the basis of examinatio and manner stated.	edge, death n and/or inv	occurred at the time estigation, in my or	ne, date and place, pinion, death occur	, and due to the cau rred at the time, dat	ise(s) and manner in and place, and di	as stated. ue to the cause(s)
To the Hospital or Attending Physician: The law requires that the death certif within 24 hours after death. To the Funeral Director: Alter this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use a	Medical Ce	29b. Signatur and title of certifier	on the basis of examination and manner stated.	n and/or inv	29c. License	number	red at the time, dat	ise(s) and manner e and place, and di	ue to the cause(s)
To the Hospital within 24 hours : To the Funeral Completely filled	edical	one)	on the basis of examination and manner stated.	n and/or inv	29c. License	number	red at the time, dat	e and place, and d	ue to the cause(s) nth, Day, Year)

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2007 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** PM James Edward McFalls, Jr. October 2007 2324 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner E1kton Cecil Union Hospital If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1 M 2 □ F Yrs. OCT 25, Director 215-90-9011 1963 Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 Is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 X Yes 2 □ No Directo Maryland Ceci1 E1kton 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 21921 United States 100 Huntsman Drive Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 M Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2X Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Completed by Specify: 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Door and Window Elementary/Secondary (0-12) College (1-4or 5+) Manufacturing Assembler 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be James E. McFalls, Sr. Darlene Miller ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carla M. McFalls/Wife 100 Huntsman Drive, Elkton, Maryland 21921 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition October 8, West Chester, 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State R.A. Ferris & Co., Inc. 4 ☐ Donation 5 ☐ Other (Specify) 2007 Pennsylvania 22. Name and Address of Facility Hicks Home for Funerals, P.A. 103 W. Stockton Street, Elkton, Maryland 21921 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Due to (or as a consequence of): /Medical **Examiner** Meloslato Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner been signed by the attending physician and should be detached for use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an this certificate has al director, page 2: autopsy performed? To the Hospital or Attending Physician: filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA မ 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural (Month, Day Year) 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident after death 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier and manner stated. 29c. License number 29b. Signature and title of certifier D00060756 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) w main St. Eleba, m 31. Date filed (Month, Day, Year) Registrar's Signature State OCT 15 2007 Registrar

State of Maryland / Department of Health and Mental Hygiene 2007 3314

			1 - State Registrar		Ce	rtificate of	Death	F	Reg. No.	UUI	33141
		Lie	Decedent's Name (First, Middle, Las	t)				2. Date of Dea	ath		3. Time of Death
	Physicia /Medic		FLORENCE M	IORI				OCT.	2 2	2007	10:00A M
	Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, o	r Location of Death			nty of Death	
			14411 POPLAR H	ILL ROAD		WALDOR	F		CH	HARLES	3
*	Funeral		Social Security Number 6. Security Number		yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day	h /. Year)	9. Birthpl Count	ace (State or Foreign
	Director		5/9-24-8964	□M 2□F	93 Yrs.	Institute Bayo	The state of the s	APR.22	,1914		
P	>		Usual Residence of Decedent 10a. State 10b. County	100	c. City, Town or Lo	ocation				10	Od Inoido City Limito
anyla	shov	_			2. Oity, TOWITOI LC	ocation				1	0d. Inside City Limits 1 ☐ Yes 2X No
Je M	8a-f	Sct	MD CHARLE	is v	WALDORF	T		· · · · · · · · · · · · · · · · · · ·			
vith t	or 2 be n	ä	10e. Street and Number			10f. Zip Code			-	of What Count	
ath v	s 23a	la la	14411 POPLAR H		5-110	20601	li			S. A.	
er de	item	Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Ever Armed Forces?	In U.S. 13.	If Yes, specify Cub	Hispanic Origin? (Span, Mexican, Puert	o Rican, etc.)		Black, White,	
hours aff	l", or xa⊞i	by F	3 XWidowed 4 ☐ Divorced	1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		1 ☐ Yes 2 ☐ No	Specify:		Spec		·Mp
III	atura a E		15. Decedent's Ed	ucation	16a. Dece	dent's Usual Occup	pation		16b. Kind of	WHI Business/Ind	
 	n "n Medi	Completed	(Specify only highest grade Elementary/Secondary (0-12)	de completed) College (1-4or 5+)	(Give	kind of work done DO NOT use retire	during most of wor d)	king			
With T	r tha	E	8th	College (1-401 5+)	HO	MEMAKER			OWN	HOME	
g ∰ g	othe ent,	Bec	17. Father's Name (First, Middle, Last)				18. Mother's Nam	ne (First, Middle,	Maiden Surn	name)	
Id be	fenta rked iic ev	To B	JOSEPH WHITE	2			VIRGI	NIA LOU	JISA W	WHITE	
shou	s mai		19a. Informant's Name/Relationship (7		19b. Maili	ng Address (Street	and Number or Ru	ral Route Numbe	er, City or Tou	vn, State, Zip	Code)
Mad 2 s	alth a		IDA FINCH-DAUG	HTER	1441	1 POPLA	R HILL	RD. WAI	DORF,	,MD. 2	20601
s + e	of He item roth	1	20a. Method of Disposition	2	0b. Place of Dispo	osition (Name of matory or other pla	ice)	Date	20c. Location	n - City or To	wn, State
Pag Pag	int: If		1 ☐ Burial 2 🛣 Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify) MET	ROPOLIT	AN CREM	ATORY 1	0-3-07	ALEX.,	,VA.	
Daltimor	Department of Health and Mental Hyglene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Licen		(2. Name and Addre	ess of FacilityRA	MOND F	UNL.	SERVI	CE, P.A.
<u>n</u> 8	2 E E S	1	Muchan o	1.			HINGTON				20646
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only	olications that caused the	death. Do not en		ng, such as cardiac	or respiratory ar		,	Approximate Interval Between
Ph	ysician		Immediate Cause (Final disease or condition		mount	we He	ent ta	llere		1	Onset and Death
	Medical		resulting in death)	Due to (or as a co	nseque v e of):	11.	1-				
E)	aminer		Sequentially list conditions	b	My	any	allul				
d e	#	iner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a co	nsequence on	U					
ecute	and trans	Examine	that initiated events resulting in death) Last	cDue to (or as a co							
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ortificate be executed	physician and s the burial-transit	Medical		.d							
Sertifi	D 60	-	IF FEMALE:	23c. If yes, outcome pf pr	regnancy				00.1	D-1	
death o	attending pl	ian	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time	Fetal death 3	⊒Ectopic pregnand ⊒ Other <i>(specify)</i> _	су			Date of delive Month	Day Year
i ş	been signed by the attendin should be detached for use	Physician	1 ☐ Yes 2 ★No 9 ☐ Unknown	9□Unknown	e or death 51	Other (specify) _					
that	ed b) detai		Part II. Other significant conditions of	ontributing to death but no	ot resulting in the o	underlying cause giv	ven in Part I.	23e. Did to	obacco use co	ontribute to th	ne cause of death?
OrdS, Prequires that	sign Id be	d by						1 🗆 🗎	Yes 2 ⊠ No	o 3 ☐ Prob	ably 4 □Unknown
COFGS v requires	beer	ete						24a. Was	an 24	Ih Were auto	nev findings available
The law	e has	Completed						autor	osy ormed?	death?	psy findings available mpletion of cause of
	s certificate has t irector, page 2 s	ပို	25. Was case referred to medical				Of Place of Day	1 Yes ath (Check only o	2 No	1 🗆 Yes	2 No
ິທ	s cert lirect	O B	examiner?	Hospital: 1 ☐ Inpatient	2 ☐ ER/Outpatie	nt 3 DOA Oti	her: 4 Nursing F			Other (Specify	w)
	eral o		27. Manner of Death	28a. Date of Injury	28b. Time			28d. Describe I			//
VISION	ith. r: Afte e fun	ţ	1 Natural 5 Pending 2 Accident investigation	(Month, Day Ye	ear) Injury		ork?]Yes 2∐No				
UIVISION I or Attending	after death. Director: After this certific I in by the funeral director,	iţi	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - building, etc. (S	At home, farm, st	reet, factory, office		28f. Location (S City or Tox	Street and Nu	ımber or Rura	l Route Number,
	within 24 hours after d To the Funeral Direc completely filled in by	Certification:	4 Li Tottiloso	building, etc. (o	респу)			City of Tol	vii, State)		
L Hospital	within 24 hours a To the Funeral I completely filled		29a. Certifier 1 Certifying Ph	ysician: To the best of m	y knowledge, dea	th occurred at the t	time, date and place	e, and due to the	cause(s) and	I manner as s	tated.
he H	in 24 t he F i	edical	uie)	and manner stated.		nvestigation, in my	opinion, death occi	ined at the time,	uate and plat	ce, and due to	o trie cause(s)
Tot	To 1	Σ	29b. Signature and title of certifier	HI m		29c. Licens	se number		29d. Date sig	gned (Month,	Day, Year)
1			Moulea	WI		194	1001		остор:	ER 2,	2007
	2		30. Name and address of person who	completed cause of death	(Item 23a) (Type	, Print)			JC IOD.	11/ Z	2007
	0		MICHAEL LEATH	ERWOOD M.	D. 120	70 OLD I	JINE CEN	TER WA	LDORF.	, MD	
	Sta √Regist	ate	31. Date filed (Month, Day, Year)	27.	Signature 1	and I			,	-	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registral AMEND#18perFH10/1/07, BMW, MoCo Certificate of Death Reg. No. 2 0 0 1. Decedent's Name (First, Middle, Last) 2. Date of Death Vilma MOIEN Month **Physician** 07 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince Georges Doctor's Community Hospital Lanham If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea July 8, 19 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** Days Hours Months 1□M 2XF Philippines 74 1933 220-88-4247 Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ral", or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 No College Park Prince Georges Maryland Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code permit. Pages 1 and 2 should be filed within 72 hours after death with a Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or any Injury or other traumatic event, the Medical Examiner must be n 20740 United States 9237 St. Andrews Place by Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married A Married Specify: White Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify If Yes, Give Year or Dates: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Dentistry Dental Assistant 18. Mother's Name (First, Middle, Maiden Surname)
Nena (Unknown) 17. Father's Name (First, Middle, Last) Be Marcial Zaguirre 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 9237 St. Andrews Place, College Park, MD 20740 Joel Moien, Husband Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 10/01/07 1 → Burial 2 □ Cremation 3 → Removal from State King David Memorial Gården |Falls Church, VA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Linera Service Licensee Torchinsky Hebrew Funeral Home 20012 254 Carroll St., NW. Washington, DC 23a. Part There the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** CANCER VDa /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) Examiner Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): been signed by the attending physician should be detached for use as the burial Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Fctopic pregnancy in the past 12 men 1 Yes 2 No 9 Unknown Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9☐Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4 nknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed Yes 2 has page 2 or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Impatient 2 ER/Outpatient 3 DOA Certification: To this completely filled in by the funeral 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 27 Manner of Death 28c. Injury at Work? A fter Vatural 2 ☐ Accident (Month, Day Year) 5 ☐ Pending investigation death 1 Yes 2 No ofter death 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospitai within 24 hours a 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) tow, O 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Greenway 1252 WELTZ MARTIN

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

0 1 2007

3 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Albert Joseph Misek 2007 9:00P Sept. 26, 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Holy Cross Hospital Silver Spring Montgomery If Under 1 Year If Under 24 Hrs. Months Days Hours Min. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 93 Days 1X M 2 □ F 577 38 8258 Dec. 15, 1913 Ohio Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 Yes 2 □ No Prince Georges Mt. Ranier 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4603 24th Avenue 20712 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 0 / 3 Was Decedent of Hispanic Origin? (Specify Yes or No if Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 √ Yes 2 No 1943 If Yes, Give Year or Dates: 1945 1 Never Married 2 Married 1 Yes 2□ No Specify Specify: White 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Electrical Engineer US Dept.of Agriculture 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Andrew Misek Elizabeth Hudacsko 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15210 Elkridge Way #2J Silver Spring,MD Adele M. Spellerberg -sister 20906 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Gate Of Heaven 10-03-2007 Silver Spring,MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Joseph Gawler's Sons, Inc. 21. Signature of Funeral Service Licensee Androu 5130 Wisconsin Ave., NW Washington, DC Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Cerebrovascular Accident disease or condition resulting in death) Due to (or as a consequence of) Congestive Heart Failure Sequentially list conditions, if any, learning to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for sels consequence of) Due to (or as a consequence of) 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown Part il. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Tyes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? 1 □Yes 2 ☑ No autopsy 2 No 1∐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2(1) No 1 🖄 Inpatient 2 ER/Outpatient 3 DOA

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

r 28a-f show notified at

"natural", or items 23a or a

7.27 is marked other than ".
Traumatic event

permit. Pages 1 and 2 should be filk Department of Health and Mental Hy Important: If Item 27 is marked oth any Injury or other traumatic event

Director

Funeral

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Completed

Be

MD

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Examiner and burial-trar physician the as attending p the

certificate be executed

Division or Vital Records, P.O. Box 68760,

Physician/Medical þ Completed page 2 s Be P Certification:

27. Manner of Death

1 **∄**Natural

detached signed by has certificate : After death. within 24 hours after death

To the Funeral Director:
completely filled in by the

To the

Hospital or Attending

2 Accident 6 Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D65485 Sipanich. Kom 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

20910

28b. Time of

State

Registrar

Medical

31. Date filed (Month, Day, Year) OCT 0 1 2007

5 Pending investigation



28a. Date of Injury (Month, Day Year)

			1 - For State Registrar	State of Maryla		epartment of F Certificate of		Mental Hy	/giene Reg. No		7 33	150
	Physicia	an	1. Decedent's Name (First, Middle, La	·				2. Date of D			3. Time of	
	/Medic		CAROLE J	<u></u>		1		SEPT	20	9 200		, by
h	Examin	ier	4a. Facility Name (If not institution, given UNIVERS 17Y OF N	,	CAL CE		or Location of Deatl	n	40	County of Dea	ith	
	Funeral		5. Social Security Number 6. S	Sex 7. Age (In yrs				8. Date of Bi	irth		thplace (State o	r Foreign
	Director		302-42-7734	1□M 2XF 67	Yı	s. Months Days	Hours Min.	Decemb			N. Da	kota
3	ow It		Usual Residence of Decedent 10a. State 10b. County	10c. C	ity, Town	or Location					10d. Inside Ci	ty Limits
	Mary Fish fied a	tor	Maryland Frederi	ck i	Mount	Airy					1 □ Yes	2 <u>X</u> No
4	or 28	Directo	10e. Street and Number			10f. Zip Code			10g. Ci	itizen of What C	ountry?	
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Mary	and Miss mar		19a. Informant's Name/Relationship		19b. i	Mailing Address (Street	and Number or Ru	ural Route Num	ber, City	or Town, State,	Zip Code)	-
e, Z	m 27		Michelle McGraw			06 Joppa Ci	rossing (,		land 21	085
יסנ	nt of h		20a. Method of Disposition 1 XBurial 2 □Cremation 3 E	Removal from State	cemetery,	Disposition (Name of crematory or other pla	· · · · · · · · · · · · · · · · · · ·	Date		ocation - City o	,	
Baltimor	permit. Pages Department of half Important: If ite any Injury or ot once.		4 □ Donation 5 □ Other (Speci 21. Signature of Funeral Services Lice		resti	awn Mem. Ga			.1		ille, M	<u>a.</u>
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i i	withi Comp	Me	29b. Signature and title of certifier	1 accorti	MI	129c. Licens	se number 563416	. 6	29d. D	ate signed (Mor	2007	
5	113.		30. Name and address of person who	completed cause of death (Ite	em 23a) (T	vpe. Print)			21			
	Sta	ate	31. Date filed (Month, Day, Year)	32 Registrar's Sig	nature	1 .	PIUKL 701	V 210	VI			
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** 27, 2007 10:00 A Bernard R. Mazurowski September /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick 4943 Tall Oaks Drive Monrovia If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Days Hours Min. (Month, Day, Year) 6. Sex Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1X M 2 □ F 80 July 18, 1927 Director 105-20-3271 Pennsylvania Usual Residence of Decedent the Maryland r 28a-f show notified at 10c. City, Town or Location 10a. State 10d. Inside City Limits 1 ☐ Yes 21X No Director Maryland Frederick Monrovia 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code with 1 ital Hygiene. d other than "natural", or items 23a or event, the Medical Examiner must be I United States death v Funeral 4943 Tall Oaks Drive 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. filed within 72 hours after 1 XI Yes 2 □ No If Yes, Give Year or Dates: WWII 1 ☐ Never Married 2 Married White 1 ☐ Yes 2 ☒ No Specify: 2 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Engineer Communications 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ith and Mental F 27 is marked ot traumatic ever Pages 1 and 2 should be Apollinia Malinowski Boleslaw Mazurowski 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a Alice Mazurowski / Wife 4943 Tall Oaks Drive Monrovia, Maryland 21770 or other of Hea 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State October 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Department of Important: If any Injury or once. St. Peter's Cemetery 2007 Libertytown, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of 22. Name and Address of Facility Stauffer Funeral Homes, P.A. neral Service Mt. Airy, Maryland 21771 8 E. Ridgeville Blvd. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each, line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ladder Cancer /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed the burial-trai Due to (or as a consequence of) Physician/Medical attending for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) 4□Pregnant at time of death detached 9 I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 3 Probably 4 ☐ Unknown 1 Yes 2 No page 2 should Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 1∐ Yes 2 **X** No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 🖾 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Certification: To

Division or Vital Records, P.O. Box 68760, Hospital or Attending Physician: director After

Maryland 21215-0036

Baltimore.

24 hours after death Funeral Director; filled in by the

within 24 ho To the Fun completely

State

and manner stated. 29b. Signature and title of certifie

5 Pending investigation

6 Could not be determined

28a. Date of Injury (Month, Day Year)

29c. License number

1 ☐ Yes 2 ☐ No

28c. Injury at Work?

Ta Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

10

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Elhamy Eskander

The street Frederick, MD 2170 501 W

31. Date filed (Month, Day, Year) OCT 0 2 2007

27. Manner of Death

Natural

2 Accident

3 Suicide

29a. Certifier

4 Homicide

(Check only one)

32 Registrar's Signature

28b. Time of

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Injury

Registrar

rysicia		Registrar 1. Decedent's Name (First, Middle, La	st)				Date of Dea Month	Day	Year	3. Time of Death
Medic		RAMD	EHAL NA	RINE			SEPT.	29,	2007	11:10 A
kamin		4a. Facility Name (If not institution, give			4b. City, Town, or		•		unty of Death	
å; -		HOLY CROSS HO 5. Social Security Number 6. S		. last birthday)	S1LV If Under 1 Year	ER SPRING If Under 24 Hrs.	8 Date of Birth	h	ONTGOM 9. Birth	place (State or Foreig
neral ector			1 X M 2□ F 59	Van	Months Days	Hours Min.	(Month, Day	1948	Cot	RINIDAD
be notified at		10a. State 10b. County	10c. C	ity, Town or Lo						10d. Inside City Limit
otifie	Director	MD. MONTGOM	ERY		SILVER SP 10f. Zip Code	RING		10g. Citizen	of What Cou	intry?
De D		10e. Street and Number	TOOD DD ADM		209	04			RINIDA	_
must	Funeral	11443 LUCK	WOOD DR. APT. 12. Was Decedent Ever in 1		Was Decedent of Hi If Yes, specify Cuba		ecify Yes or No-		Race - Amer	ican Indian,
dical Examiner must	by Fun	1 □ Never Married 2 Married 3 □ Widowed 4 □ Divorced	Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		If Yes, specify Cuba 1 ☐ Yes 2 X No		Rican, etc.)	1	Black, White becify:	r, etc.
dical Ex		15. Decedent's E (Specify only highest gr	ducation	(Give	dent's Usual Occupa	turing most of worl	king	16b. Kind	of Business/I	
the Me	Completed	Elementary/Secondary (0-12)	College (1-4or 5+) 4		DO NOT use retired SECURITY			ARGE	NBRIG	T SECURIT
event,	Be C	17. Father's Name (First, Middle, Las	t)		İ	18. Mother's Nam	e (First, Middle,	Maiden Su	rname) U	NK.
	10 E	CHATTER	GOSINE				ROOKMIN			
auma		19a. Informant's Name/Relationship	(Type. Print)	-	ng Address (Street a					
other traumatic		INDRA RAMDEHA				D DR. AP	T. A-4,		IR SPR	ING, MD.20
- 10		20a. Method of Disposition 1 ☐ Burial 2 ▼ Cremation 3 4 ☐ Donation 5 ☐ Other (Spec	Removal from State	cemetery, cre	osition (Name of matory or other places S CREMATO	1	2-2007		ERDALE,	
any Injury o		21. Signature of Funeral Service Lice	ensee	Č	2 Name and Addres HAMBERS F 801 CLEVE	ss of Facility UNERAL H	OME & CE	REMATO	RIUM,I	P.A. 20737
physician and dical niner transit sthe burial-transit	edical Examiner	23a. Part1. Enter the disease, or conshock, or heart failure. List only mmediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. CEREBROVASC Due to (or as a consc END STAGE I Due to (or as a consc C. Due to (or as a consc d.	CULAR A equence of): RENAL D equence of):	CCIDENT					
been signed by the attending pny should be detached for use as the	Physician/Media	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome pf preg 1 □Live birth 2 □ Fc 4 □ Pregnant at time o 9 □ Unknown	etal death 3	□Ectopic pregnanc	<i>y</i>		230	d. Date of del Month	ivery Day Year
signed by	b	Part II. Other significant conditions	contributing to death but not r	esulting in the t	underlying cause giv	en in Part I.				the cause of death
ge 2 should	Completed						24a. Was	an	24b. Were at prior to death?	utopsy findings availa completion of cause 2 \(\sum \) No
pa	Be	25. Was case referred to medical examiner?	Librariani.		I C II	26. Place of Dea				
ertificate ector, pa	2	1 ☐ Yes 2 ☐ No 27. Manner of Death 1 ☐ Natural 5 ☐ Pending	Hospital: 1 Inpatient 2 28a. Date of Injury (Month, Day Year,	ER/Outpatie	of 28c. Inju	ry at rk?	lome 5 ☐ Resi 28d. Describe			ecify)
After this certificate ineral director, pa				t home, farm, s		Yes 2 □ No	28f. Location (City or To	(Street and wn, State)	Number or R	ural Route Number,
Director: After this certificate in by the funeral director, pa		2 Accident investigati 3 Suicide 6 Could not 4 Homicide determine		ecify)			I .			
Funeral Director: After this certificate has tely filled in by the funeral director, page 2	Certification:	3 Suicide 4 Homicide 6 Could not determine 29a. Certifier (Check only 2 Medical Ex	building, etc. (Spe Physician: To the best of my aminer: On the basis of exam	cnowledge, dea	ath occurred at the ti	me, date and place	e, and due to the urred at the time	cause(s) a	ind manner a place, and du	s stated. e to the cause(s)
o the Funeral Director: After this certificate ompletely filled in by the funeral director, pare		3 Suicide 6 Could not determine	building, etc. (Spe	cnowledge, dea	ath occurred at the ti investigation, in my 29c. Licens	opinion, death occ	e, and due to the urred at the time	, date and p	olace, and du	s stated. e to the cause(s) th, Day, Year)
To the Funeral Director: After this certificate completely filled in by the funeral director, pa	edical Certification:	3 Suicide 4 Homicide 29a. Certifier (Check only one) 29b. Signature and title of certifier	building, etc. (Spe Physician: To the best of my aminer: On the basis of exam	cnowledge, dea	investigation, in my 29c. Licens	opinion, death occ	urred at the time	, date and p	olace, and du	e to the cause(s) th, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1- State of Maryland / Department of Health and Mental Hygiene Registrar

State of Maryland / Department of Health and Mental Hygiene Registrar

Por Amend Items 23a, 25 per me, g872 10/11/07dhb
Registrar 2. Date of Death 1. Decedent's Name (First, Middle, Last) September 20, Year 2007 **Physician** 6:45 PM Laura R. Nash /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Montgomery General Hospital 01ney Montgomery If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months Days Hours Min. 10/20/1918 1 □ M 2 🔀 F NY 88 Director 055-03-5189 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygjene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1X Yes 2 No Director MD Montgomery Gaithersburg 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 9140 Centerway Road 20879 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify ģ 3 Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Laboratory Research Assistant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be (Bessie Belford Harry Kopeikin 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9140 Centerway Road Gaithersburg, MD 20879 Barbara Goldstein-Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☑ Removal from State King David Mem.Grdns. 09/23/2007 4 ☐ Donation 5 ☐ Other (Specify) Falls Church, VA 22. Name and Address of Facility Danzansky-Goldberg Memorial Chapels, Inc. 1170 Rockville Pike
Rockville, MD 20852 21. Signature of Fundal Service Licensee Chapels, Inc. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on pach line. Approximate Interval Betw Onset and Death itonitis Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sin oranon Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Ischemic Colitis Examiner OPPROVED BY MEDICAL The law requires that the death certificate be executed and burial-trai Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician for use as the buria CERTIFICATION Physiclan/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month in the past 12 months? 1☐Yes 2☑No 4☐Pregnant at time of death 5 ☐ Other (specify) the 9□ Unknown 9 ☐ Unknown 23e. Did tohacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ð 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsv performed? Yes 2 No this certificate or Attending Physician: director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 1 **1** es 2 € 2 ER/Outpatient 3 DOA Medical Certification: To n by the funeral 27. Manner of Death Natural XXIII Matural 5 Pending 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after dear 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 Homicide filled Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 0063999

DHMH 17 Rev 1/2001

State

Registrar

12

Olney, MD 20832

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

OCT 1 2 2007

Ata Motamedi 18101 Prince Philip Drive

Registrar's Signature

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			1 - State Registrar			rtificate of		, ,	Reg. No. 2	07 (3315
	Physici	212	1. Decedent's Name (First, Middle, La	st)				2. Date of Dea	ath Day	Year 3.	Time of Death
	Physici /Medio		HARVEY RAY NO	ORRIS					28,2007		:30P M
	Examin	er	4a. Facility Name (If not institution, given	e street and number)		4b. City, Town, o	or Location of Death	1	4c. County	of Death	
			CHARLOTTE HA				TTE HAL		ST.MA		
-	Funeral Director		5. Social Security Number 485-09-2633 Usual Residence of Decedent	Sex 7. Ag	ge (In yrs. last birthday) 89 Yrs.	If Under 1 Year Months Days		8. Date of Birt (Month, Day 1 - 4 - 1 9	y, Year)	9. Birthplace Country) IOWA	(State or Foreigr
	land ow		10a. State 10b. County		10c. City, Town or Lo	cation				10d. lr	nside City Limits
	72 hours after death with the Maryland "natural", or Items 23a or 28a-f show cdical Examiner must be notified at	tor	MD. ST.MA	RY'S	CHARL	OTTE HA	$_{ m LL}$			1	□Yes 2∏No
	r 28a	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of V	Vhat Country?	
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and	uld be f fental l rked of	Be	ARCHIE NORR				1	HOUTS	warden ouman	0)	
	shoulk nd Me mark martic	ဥ	19a. Informant's Name/Relationship		19b. Maili	na Address (Street	t and Number or Ru		er. City or Town	State Zin Cod	e)
Mary	nd 2 s lith ar 27 is rtrau		HARVEY NORRI			_	RD. PO		-		•
<u>၈</u>	tem		20a. Method of Disposition		20b. Place of Dispo	sition (Name of	i	Date	20c. Location -	City or Town, S	
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Baltimore,	permit. Pa Departmen Important: any Injury		21. Signature of Funeral Service Lice		79 R	2. Name and Addre AYMOND	ess of Facility FUNERAL	SERVI			
ı	1		23a. Part1. Enter the disease, or con shock, or heart failure. List only	plications that caused	d the death. Do not en	er the mode of dy	MD 20 ing, such as cardiac	or respiratory ar	rest,	Apr	roximate
	Physician		Immediate Cause (Final	one cause on each li	ne.	· ~ h	che to	Nu.	1.	Ons	rval Between set and Death
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α ×	death certificate e attending phys d for use as the	Physician/Medi	IF FEMALE:	00-1/						100	
POZ	ath c	ian	23b. Was decedent pregnant in the past 12 months?		2 Fetal death 3	Ectopic pregnanc	СУ		23d. Dat Mo	te of delivery onth Day	Year
j.	he de the s	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant a 9□Unknown	t time of death 51	Other (specify)_					
7.	w requires that the d been signed by the should be detached		Part II. Other significant conditions	contributing to death b	out not resulting in the u	nderlying cause gi	ven in Part I.	23e. Did to	obacco use conti	ribute to the ca	use of death?
as,	uires sign d be	d by	din	enlite	1			1 🗆 1	Yes 2 No	3 ☐ Probably	4 Unknown
ecord	v req been shoul	ete	10.00	0.00	, (24a. Was	an Jash	Mara autonou f	indings available
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VITAI	in: Ti ficate or, pa		25. Was case referred to medical				00 Pl	1 Yes	241No 1	1 □ Yes 2 □	No
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00	ndlny tth. r: Afte e fun	tion	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(<i>Month, Da</i> n	ny Year) Injury		ork?]Yes 2.∏No				
DIVISION	tal or Attending Physician: rs after death. al Director: After this certific ed in by the funeral director,	ertification:	3 Suicide 6 Could not be determined	28e. Place of inj	ury - At home, farm, st tc. (Specify)	reet, factory, office		28f. Location (S City or Tox	Street and Numb	er or Rural Ro	ute Number,
5	tal or Attending Physician; rs after death. al Director; After this certifica led in by the funeral director, I	Cert		building, ea	(opcony)		1	5.1y 51 70V	, o		

To the Hospita within 24 hours To the Funera completely fille 5+1

29a. Certifier (Check only one)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

D0057574

30. Name and address of person who completed cause of death (Item 23a) (Type, Pript)

DR. HESHMAT 29449 Charlette HALL Sch. Rd. Charlotte Hall, and.

31. Date filed (Month, Day, Year) OCT 0 9 2007 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Date of Death
 Month 1. Decedent's Name (First, Middle, Last) **Physician** Constance Louise O'Keefe September 25, 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Suburban Hospital Bethesda Montgomery If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 M 2 X F 23, 041-22-7721 79 Director 1927 Connecticut Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10b. County must be notified at 1 ☐ Yes 2 No Director Maryland Montgomery Silver Spring 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20902 11708 Kemp Mill Road USA item 27 is marked other than "natural", or items 23a other traumatic event, the Medical Examiner must t Funeral Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: White Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) **Executive Secretary** Insurance & Law 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Lissandrillo Gasper Lucy Malandrino ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Leo Florence O'Keefe/Husband 11708 Kemp Mill Road, Silver Spring, MD 20902 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of Important: If it any injury or o once. 1 ☐Burial 2 ☐ Cremation 3 ☐ Removal from State Gate of Heaven Cemetery 2007 Silver Spring, Maryland 4 Donation 5 Dother (Specify) 21. Signature of uneral Service License 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd, W., Silver Spring, MD 20901 Approximate Interval Between Onset and Death ns that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, use on each line. 23a. Part1. Enter the disease, or compleshock, or heart failure. List only o Immediate Cause (Final disease or condition resulting in death) Physician metastatic carcinona months /Medicai Due to (or as a consequence of): **Examiner** Sequentially list conditions, any leading to miscale cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Physician/Medical Examiner requires that the death certificate be executed 200-Due to (or as a consequence of) IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 Probably 4 Unknown 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 1☐ Yes 2 No or Attending Physician: 25. Was case referred to medical Medical Certification: To Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA or 28a. Date of Injury (Month, Day Year) 27. Mann Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Division 1 Natural Injury 5 | Pending To the Hospital or Attendii within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Sofo no tember 25, 2007 grown -30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD 9707 Medical Center Drive #300 Rocieville MD 2000 GEONGE SOTOS 32 Registrar's Signature 31. Date filed (Month, Day, Year) State 02 2007 Registrar

DHMH 17 Rev 1/2001

8.20am

O'Keefe, constanc

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Sept. **Physician** PATIENCE ZOO ()du 12:05 PM FUNMIL AYO /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ADT. F DRIVE FREDERICK FREDERICK 600 HEATHERIDGE 8. Date of Birth Month, Day, Y 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🗹 F Days Hours 225-63-9251 70 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ns 23a or 28a-f show must be notified at FREDERICK FREDERICK 1 Yes 2 No MD Funeral Director death with the 10e. Street and Number 10g. Citizen of What Country? 600 HEATHERIDGE DRWE ADT F 21702 J. S. A. ural", or Items 2 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. Black, White, etc. Pages 1 and 2 should be filed within 72 hours after of the sound of Health and Mental Hygiene.
Int: If Item 27 is marked other than "natural", or Item 1 Never Married 2 Married 1□Yes 2☑No altimore, Maryland 21215-0036 Specify: BLACK Completed by Specify: 3 ☐ Widowed 4 ☐ Divorced er than "natur , the Medical I 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) DRIVATE Elementary/Secondary (0-12) College (1-4or 5+) CAREGINER FAMILIES TH 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be SOMITFUN ADEBAYO DORCAS ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 18314 LECOSTOWN WAY OINEY MD. 20832 TONEY MOSUNMADE (SON) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of Important: If it any Injury or o 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State OCT. 19, 2007 LAGOS, NIGERIA ATTA COMBREY 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility ADY L. POLLINS FUNCIA HIME say a. 110 WEST SOUTH ST FRODERICK MD 21701 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final MULTIPLE MYELOMA Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine requires that the death certificate be executed physician and the burial-tran Due to (or as a consequence of) P.O. Box 68760, Physician/Medical ast IF FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal deat 4☐Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 2 Fetal death 3 DEctopic pregnancy Month Year Day 5 ☐ Other (specify) been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy 1□ Yes 2 No or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) ۴ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Peath 28a. Date of Injury (Month, Day Year) 28h. Time of Medical Certification: 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director: A 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

State Registrar 29b. Signature and the of certifier

31. Date filed (Month, Day, Year)

OCT 0

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Figistrar's Signatur

convert was 50 Ca. SEVENTH ST.

29c. License number

29d. Date signed (Month, Day, Year)

FREAERICK MO 21701

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death September Da **Physician** 4:55 AM 25, 2007 Johnnie E. Owens /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore Washington Medical Center Glen Burnie Anne Arundel 8. Date of Birth (Month, Day, Year 7/22/1922 If Under 1 Year If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country) NC 5. Social Security Number **Funeral** 1 □ M 2 🔀 F Director 243-22-1515 85 Usual Residence of Decedent the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f show be notified at 1 ☐ Yes 2☐No Director MD Anne Arundel Odenton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2493 E. Amber Orchard Ct. #201 21113 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 전 No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No White Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) item 27 is marked other than other traumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) 12 Telephone Operator State of Maryland 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John Daniel Edwards Ruth Smith 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

permit. Pages 1
Department of H
Important: if ite
any injury or ot
once.

Physician /Medical Examine

within 24 hours a To the Funeral C

To the Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760,

	Immediate Cause (Final disease or condition resulting in death)	a Acute Renal Failure		Onset and D
ner	Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a consequence of):		
lical Examiner	Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as a consequence of):		
Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify)	23d. Dat	e of delivery nth Day Y
Completed by Pł	Part II. Other significant conditions co	ontributing to death but not resulting in the underlying cause given in Part I.	24a. Was an autopsy 24b. V	3 ☐ Probably 4 ☑ 0 Were autopsy findings a prior to completion of ca
			performed 6	leath? ☐Yes 2∰No
Be	25. Was case referred to medical examiner?	26. Place	of Death (Check only one)	
မ			sing Home 5 Residence 6 Other	er (Specify)
	27. Many er of Death 1 2 Natural 5 Pending 2 Accident investigation		28d. Describe how injury occurr	ed
Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Numb. City or Town, State)	er or Rural Route Numb
cal (29a. Certifier 1 Certifying Phy (Check only 2 Medical Exam	vsician: To the best of my knowledge, death occurred at the time, date and iner: On the basis of examination and/or investigation, in my opinion, deat	d place, and due to the cause(s) and math occurred at the time, date and place,	nner as stated. and due to the cause(s)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

SEP 2 8 2007

Mathis Owens

20a. Method of Disposition

Spouse

MXBurial 2 ☐ Cremation 3 department of a depa	□Removal from State Ma	ryland Vet	Cemetery 9/2	8/2007 C	rownsville	e, MD
21. Signature of Funeral Service him		22. Name	and Address of FacilityHa	ardesty Fun		, P.A.
23a. Part1. Enter the disease, or con shock, or heart failure. List onl	mplications that caused the d	eath. Do not enter the n	node of dying, such as card	diac or respiratory arrest	,	Approximate Interval Between
rnmediate Cause (Final disease or condition esulting in death)	a. Acute Due to (or as a cons		ailure			Onset and Death
sequentially list conditions, ausse. Enter Underlying Cause (Disease or injury hat initiated events esulting in death) Last	b. Due to (or as a none c. Due to (or as a cons d.	equenne of):				
F FEMALE: 33b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome pf pre 1 □ Live birth 2 □ F 4 □ Pregnant at time of	etal death 3 □Ectopic	c pregnancy (specify)		23d. Date of deliv	very Day Year
art II. Other significant conditions	contributing to death but not	resulting in the underlyin	g cause given in Part I.		cco use contribute to	
				24a. Was an autopsy performe	dz prior to co	topsy findings available ompletion of cause of 2 PNo
5. Was case referred to medical examiner?				Death (Check only one)		
1 ☐ Yes 2 ☑ No	Hospital: 1 Inpatient 2	☐ ER/Outpatient 3☐	DOA Other: 4 Nursin	g Home 5 ☐ Residenc	e 6 Other (Spec	rify)
7. Manuer of Death	28a. Date of Injury	28b. Time of	28c. Injury at Work?	28d. Describe how	injury occurred	

30 Name and address of person, who completed cause of death (Item 23a) (Type, Print) Drive, Glen Burnie, MD. 20061
TEOVICE E. WICKS M.D., 301 HOSPITAL Drive, Glen Burnie, MD. 20061

M nD.

egistrar's Signature

2493 E. Amber Orchard Ct.

Date

20b. Place of Disposition (Name of cemetery, crematory or other place)

Odenton, MD 21113

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year) September 25, 2607

20c. Location - City or Town, State

DHMH 17 Rev 1/2001

State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month 200^{rea} Senetta Renee Pitts-Lancaster Sept.23, 0651 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Suburban Hospital Bethesda Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Dec. 15, 1959 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2 M 47 577-84-7745 Yrs. Director Wash.D.C. Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits 28a-f show notifled at MD Montgomery Kensington 1 X Yes 2 ☐ No Directo 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? or than "natural", or Items 23a or the Medical Examiner must be 10225 Frederick Ave #504 20891 U.S.A. permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a any injury or other traumatic event, the Medical Examiner must once. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates: 1 Never Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No þ 3 Widowed 4 Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 4 Program Analyst Gov. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Fauntleroy Jesse Webster Ann ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8643 Greenbelt Rd.#103 Greenbelt, MD. 20770 19a. Informant's Name/Relationship (Type. Print) Walter T.Lancaster-Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 In Cremation 3 ☐ Removal from State Riverdale Park Riverdale, MD. 9-3-2007 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Moense 22. Name and Address of Facility Hunt Funeral Home 908 Kennedy St.N.W.Washington, DC 20011 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between immediate Cause (Final disease or condition resulting in death) Onset and Death **Physician** METHSTATIO /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine I or Attending Physician: The law requires that the death certificate be executed after death. Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Month Day 4□Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 No 2 No 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Cify or Town, State) 4 Homicide To the Hospital within 24 hours a To the Funeral I 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2007

DHMH 17 Rev 1/2001

State

Registrar

PITIS-LANCASTER, SENETTA 9/23/07

Herminder S.Sethi 1400 Forest Glen Rd. #435 Silver Spring, MD. 20910

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

W 2 2007

32. Registrar's Signature

Amend Items 23b, c, 25 per me, 2672, 10/11/0 dip ary land Mental Hygiene 2 0 0 7 1 - For P. State Registrar 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day Perry Power **Physician** 0247 AM May 18 2007 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Johns Hopkins Bayviau Medical Center Baltimore Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex **Funeral 1**√ M 2□ F Months Days Hours 225-26-6003 89 Director Aug 16, 1917 V/A Usual Residence of Decedent and 2 should be filed within 72 hours after death with the Maryland eaith and Mental Hygiene. 10d. Inside City Limits 10c. City. Town or Location r 28a-f show notified at 10b. County 1 ☐ Yes 2 ☐ No Director MD Baltimore Rosedale 10g. Citizen of What Country? 10f, Zip Code 10e Street and Number must be n USA 4132 Prape Hill Ave 21236 items 23a Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠X'es 2 □ No If Yes, Give Year or Dates: 14. Race - American Indian 11. Marital Status Black, White, etc. XK Never Married 2 ☐ Married 0, 1 ☐ Yes 2XXNo Saltimore, Maryland 21215-0036 Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced "natural", Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) 12 Electrician permit. Pages 1 and 2 should be filed I Department of Health and Mental Hygie Important: If Item 27 is marked other 1 any injury or other traumatic event, th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ဨ Minnie M. Skinner Harry A. Power 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 4132 Prape Hill Ave, Rosedale, MD 21236 William M. Wilson Grandson 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory May 24, 2007 Balto., MD 21. Signature of Funeral Service 22. Name and Address of Facility Fink Funeral Home, P.A. 426 Crain Hwy S, Glen Burnie, MD * Gregory Fink M01148 vications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, the cause on each line. Approximate Interval Between Onset and Death nter the dis 23a, Part1 shock. Immediate Cau e (Final disease or condit n resulting in death) Failure 30 minutes Respirator **Physician** /Medical Due to (or as a consequence f) Examiner Aspiration Pneumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner CERTIFICATION APPROVED BY MEDICAL Complications of Cerebrovascular Accident The law requires that the death certificate be executed the attending physician and hed for use as the burial-trar Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months? 1☐ Yes 2☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 I Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy page 2 s this certificate has 1∏ Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Hipatient 2 ER/Outpatient 3 DOA 1 Yes 20 Certification: To 28d. Describe how injury occurred 27. Manner of Death 1 ■ Natural 28b. Time of 28a Date of Injury 28c. Injury at Work? After 1 (Month, Day Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after death Funeral Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Wertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certific D0057658 May 18, 2007 30. Name and address of person completed cause of death (Item 23a) (Type, Print) Reynolds Stasia Statt 4940 Eastern Avenue Baltimore. MD 32. Registrar's Signature 31. Date filed (Month, Day, Year) OCT 1 2 2007 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death September 26 Z007 **Physician** 0235 M ter rances /Medical 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner The memorial Hospital Talbot Easton If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1 M 2 F **Funeral** Months Days Hours 7-42-5512 Dec. 04, 1944 Maryland Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Pres 2 No Funeral Director Talbot aston 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 12. Wat Decedent Ever in U.S. Armed Forces? 21601 <u>US</u> 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Yes 2 If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ₺ No Specify: ģ Specify: Black 3 ☐ Widowed 4 Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) HouseKeeper 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Potter ၉ Henson Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Denise Street Easton, MD, 2/60
Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 10/6/07 Easton, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Richards Mem. Park 22, Name and Address of Facility HENRY FUNERAL HOME, P.A. 510 Washington St. Cambr 21. Signature of Funeral Service Licensee Cámbridge MD. 21613 23a. Party. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** metistatic (do /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 1 Yes 2 ₽1No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 HN0 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Box 68760 P.O. Records, Division or Vital death with the Maryland

filed within

Maryland

Baltimore,

Hygiene.

1 and 2 should be Health and Mental

Pages 1

Department of Health Important: If Item 27 any Injury or other tr

27

7 is marked other than "natural", or items 23a or 28a-f si traumatic event, the Medical Examiner must be notified

that the death certificate be executed and burial-trar physician the as attending properties for use as signed by the sign of the sign pate has t certificate Hospital or Attending Physician: director, this After t hours after death. within 24 hours after death

To the Funeral Director;
completely filled in by the To the

> State Registrar

29a. Certifier

(Check only one)

29b. Signature and title of certifier

and manner stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

PD59762

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) South Washington Street

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 = State of Maryland / Department of Fleath & State of Maryland / Department of Fleath & State RegistrAmended 10/01/07, items#20a, b, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** Leslie Palmer 2007 10: 02 A M tamela Sept /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Man Knd Medical Center If Under 1 Year | If Under 24 Hrs. Miversity 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6 Sex **Funeral** 22-48-8126 Months Days Hours Min 1 M 2 D 36 Director 06/07 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 XYes 2 No Directo MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? RZM5018 Deamore 2121 Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes Ž No Specify. δ Specify: B 3 ☐ Widowed 4 ☐ Divorced lack Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Pages 1 and 2 should be filed withi nent of Health and Mental Hygiene. int: if item 27 is marked other than eaner 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ျှ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other trai 305 Rouzahn Fede Joanna Payton -12/5b WIS 2(632 515tp 20a. Method of Disposition

1 □ Burial 2 A Cremation 3 □ Removal from State
4 □ Donation 5 □ Other (Specify) 20h. Place of Disposition (Name of 29c. Location - City or Town, State Captical creematory lace) 10/01/2007 Dover, DE Cambridge Smither 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 514-Roce 24 ambrida unde Ot. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) UMSC PSIS **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner law requires that the death certificate be executed burlal-transit and Due to (or as a consequence of): Box 68760 attending physician for use as the burla Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy signed by the atte in the past 12 months? 1 ☐ Yes 2 █ No Month Day Year 4□Pregnant at time of death 5 Other (specify) Division or Vital Records, P.O. 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 2 No 3 Probably 4 Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 1 No 24a. Was an has autopsy performed? Yes 2 certificate 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Thipatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 NO in 24 hours after comment the Funeral Director; After this of the funeral director and the funeral director that the funeral director and the fune 1 ☐ Yes 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Hospitai or Attending 5 Pending investigation 1 V Natural 1 Yes 2 No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Deertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 29a. Certifier To the Hosp within 24 hor To the Fune completely f 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) AU4174635K17342 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Street Baltimore, MD 21201 22 South Greene 32. Registrar's Signature State 2007

DHMH 17 Rev 1/2001

Registrar

			For State Registrar		State of M		ertificate of t			g. No.	33102
			1. Decedent's Name	(First, Middle, Las	t)				2. Date of Death Month		3. Time of Death
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	Funeral Director		5. Social Security N 215–52–21	22	ØM 2□F	ge (In yrs. last birthday 60 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, Feb 25,	1947	place (State or Foreign ntry) MD
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	28a-	ect	10e. Street and Nur	nber			10f. Zip Code		10	g. Citizen of What Cou	ntry?
	3a or	Funeral Director	36399 Day	is Street	L		21874	Į.		USA	
	death ms 2	Jera	11. Marital Status		12. Was Decedent Armed Forces	Ever in U.S. 13	. Was Decedent of H		pecify Yes or No-	14. Race - Ameri Black, White	
21215-0036	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examinar must be natified at	by Fu	1 🗀 Never Mami	ed 2 Married 4 Divorced	1 Yes 2 If Yes, Give Year or Dates:		1 ☐ Yes 2 ☐ No		0 1 1104.1, 510.7		lack
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	Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of De	eath	4c. County of Death	h
			504 Skipjack Court 5. Social Security Number 6. Sex 7. Age (In)	yrs. last birthda	E1kton	Irs. 8. Date of Birtl	Cecil	hplace (State or Foreign
	Funeral Director		5. Social Security Number 6. Sex 1 № M 2 ☐ F 7. Age (In) 1 № M 2 ☐ F 74 Usual Residence of Decedent	Yrs.		Month, Day April 9	v. Year) Co	th Carolina
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	r 28s	Directo	10e. Street and Number		10f. Zip Code		10g. Citizen of What Co	ountry?
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9036	ours afte rai', or it Examin	þ	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates:		1 ☐ Yes 2 🎇 No Specify:			ite
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12	within ene. then	Completed	College (1-4or 5+)		ason		Construc	ction
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ary	shou and M e mar umat	19	19a. Informant's Name/Relationship (Type, Print) Personal	19b. Ma	tiling Address (Street and Number of	r Rural Route Numbe	ar, City or Town, State, a	Zip Code)
ž	er tre		William R. Denny/Representati				n. MD 21921	
Baltimore, Maryland 21215-0036	permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Heelth and Mental Hygiene. Importent: If Item 27 is marked other then "natural", or Iteme 23a or 28a-f ehow eny injury or other treumatic event, the Medical Examiner riust be notified at once.		1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State	cemetery, c	position (Name of rematory or other place) Oct	cober 11,	Bay View, Maryland	Town, State
Balti	permit. I Departm Importe eny inju		21. Signature of Funeral Service Licensee		22. Name and Address of Facility Hicks Home for Fu 103 W. Stockton			land 21921
			23a. Part . Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line.	death. Do not	enter the mode of dying, such as car	diac or respiratory ai	rrest,	Approximate Interval Between
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM/20b perFH C872 10/15/07 WS
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Month **Physician** 7:00 P JANICE YEWON SEPT. PLUMER /Medical 30 2007 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 26782 LYNNDALE COURT MECHANICSVILLE MARY'S If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days 1 □ M 2 🗷 F Director 212-38-3906 66 JUNE 2,1941 VIRGINIA Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State show at 1 ☐ Yes 🏋 No ral", or items 23a or 28a-f sh Examiner must be notified Director MD ST. MARY'S MECHANICSVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a 26782 LYNNDALE COURT 20659 U. S. A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No þ Specify. Specify: 3 Widowed 4 □ Divorced Year or Dates: "natural" WHITE Completed 27 Is marked other than "natu traumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Health and Mental Hygiene. 12 **HOMEMAKER** OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be DENNY WILLIAM KISER STELLER HAYDASSIE SIMERLY ٥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) HTER 26782 LYNNDALE CT. MECHANICSVILLE, MD20659

20b. Place of Disposition (Name of cemetery, crematory or other place)

Date 20c. Location - City or Town, State PATRICIA GALENTINE/DAUGHTER 20a. Method of Disposition permit. Pages 1 Department of H Important: If ite any Injury or ot once, 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State October 4, 2007 LA PLATA 4 ☐ Donation 5 ☐ Other (Specify) DENTSVILLE METH MD 22. Name and Address of Facility RAYMOND FUNL. SERVICE, P.A. 21. Signature of Funeral Service Licensee MOG RO 5635 WASHINGTON AVE. LA PLATA MD20646 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final eta **Physician** Cancer disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 1 2 No Day Year 4 Pregnant at time of death 5 ☐ Other (specify) signed by the a 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 9 1 Ses 2 No 3 Probably 4 Unknown been si Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has certificate has rector, page 2 autopsy performe 1 Yes 2 No To the Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No funeral dir Medical Certification: To 1 🔲 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: /
completely filled in by the f 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29c. License number + 40055751 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) OCTOBER 1, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SCHMIDIT, D. U. Registrar's Signature

State Registrar

JENN**I**FER

31. Date filed (Month, Day, Year)

Μ.

2007

OCT 0 9

DHMH 17 Rev 1/2001

Danis J

40900 MERCHANTS LN.LEONARDTOWN, MD 20650

State of Maryland / Department of Health and Mental Hygien $_{200}$ 33165 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death $-29^{Day} - 2007^{Y}$ **Physician** Month 09 Year Emanuel Quarles, Sr. 6:00 A M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Larkin Chase Health Care Prince Georges Bowie | House 1 Year | If Under 24 Hrs. | 8. Date of Birth | 9. Birthplace (State or Foreign Months | Days | Hours | Min. | 01/06/1912 | South Carolina 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral X**□M 2□ F 250-10-5037 95 Yrs. Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits or 28a-f ehow the Medical Examiner must be notified at 1 Yes 2 No Director MD P.G. Fairmont Height's 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 914 60th Avenue or Items 23a 20743 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 💆 No If Yes, Give Year or Dates: Race - American Indian Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "naturel", or Item eny Injury or other traumatic event 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: Black 2 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Prince Georges Elementary/Secondary (0-12) College (1-4or 5+) Ground Supervisor Community College NONE 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) John Quar1es Jessie Holloway 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
13200 Martha's Choice Circle 20720 19a. Informant's Name/Relationship (Type, Print) James Johnell Quarles/son 13200 Martha's Choice Circle 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Maryland National 10/6/2007 Laurel, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 420 H Street NE. 21. Signature of Funeral Service Line name 22. Name and Address of Facility B.K. Henry Funeral Home Wash., D.C., 20002 Approximate Interval Between Onset and Death Part 1. Anter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Lardiamyapath /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (brias a consequence of) Examiner The law requires that the death certificate be executed burial-transit attending physician and that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760 Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months? Month 4□ Pregnant at time of death 5 Other (specify) P.O. | the a detached 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ pe 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown ted Complet 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No certificete 1 Yes 2 XNo Division of Vital Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death | Check only one examiner' Other: 4 X Nursing Home 5 A Residence 6 Other (Specify) 1 ☐ Yes 2 🙀 No 1 Inpatient 2 ER/Outpatient 3 DOA his funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 1 XNatural 5 Pending death. М 1 ☐ Yes 2 ☐ No 2 Accident investigation Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by after 4 Homicide 24 hours a 29a. Certifier Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. pletely Z Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) within 24 29b. Signature and the of certifier 29d. Date signed (Month, Day, Year) D4 5660 30. Name and address of person who completed caus of death (Item 23a) (Type, Print) 124 GALLANTICX (01, 300. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#5 per FH G872 10/19/07 WS
State of Maryland / Department of Health and Mental Hygien 0 7 3 3

Certificate of Death Reg. No.

			For State Registrar	State of Marylar	Certificate of	Death	Reg. No.	007 33166
	Physici /Medio		1. Decedent's Name (First, Middle, Last)	ANIEL Q	NINN	M	ate of Death lonth Day	25, 2007 3. Time of Death
	Examir Funeral Director		210-13-3010	rigedt enis	ral Bal	or Location of Death If Under 24 Hrs. 8. De Hours Min. (W.	ate of Birth fonth, Day, Year)	9. Birthplace (State or Foreign Country) MD.
	Maryland -f show	tor	Usual Residence of Decedent 10a. State 10b. County FRLD		ty, Town or Location REDERICK			10d. Inside City Limits 1 ☑ Yes 2 ☐ No
	th with the 23s or 28s	Funeral Director	10e. Street and Number S129 OLD	NATIONAL	PIKE 10f. Zip Code	21702		zen of What Country?
920	be filed within 72 hours after death with the Maryland stal Hygiene. do other than "natural", or items 23a or 28a-f show event, the Medical Exona her must be notified at	Ď	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	13. Was Decedent of If Yes, specify Cut	Hispanic Origin? (Specify Y ban, Mexican, Puerto Rican, Specify:		14. Race - American Indian, Black, White, etc. Specify: BLACK
21215-0036	within 72 ho iene. r than "natur the Medical	Completed	15. Decedent's Edu (Specify only highest grade	cation completed) College (1-4or 5+)	16a. Decedent's Usual Occu (Give kind of work done life. DO NOT use retire	during most of working	16b. Kir	nd of Business/Industry
Maryland 2	uld be filec Mental Hyg irked other	To Be C	17. Father's Name (First, Middle, Last) STEVEN D, Q	UINN		18. Mother's Name (First		
	ges 1 and 2 should nt of Health and Men i if item 27 la marke or other traumatic		19a. Informant's Name/Relationship (Ty)	NN (FATTER) 5129 OLD 1	NATIONAL P	IKE FRE	Town, State, Zip Code) Z1702 DERICK MO
Baltimore,	rtmer rtant njury		20a. Method of Disposition 1		Place of Disposition (Name of cometery, crematory or other place)	. OC. 2, 2		cation - City or Town, State DERICK, MD, LINS FEW. Herm E
Ba	Depa Impo any i		21. Signature of Funeral Service License	Polleis	110 Wt37	SOUTH ST	ERTOLAI	ICR MD 21701
	Physician /Medical Examiner		23a. Pari . Enter the disease, or complishock, or hear failure. List only or Immediate Cause (Final disease or condition resulting in death)	Que to (or as a consec	juence of):		iratory arrest,	Approximate Interval Between Onset and Death
,09	tificate be executed by physician and as the burial-transit	al Examiner	if any, leading to immediate	Due to (or as a consect Throve) Due to (or as a consect Se Osl	nuence of): I taile nuence of):	- hemorr	hage	1day
ς 68760,		Medic	IF FEMALE:					1000
P.O. Box	The law requires that the death cer atte has been signed by the attendir bage 2 should be detached for use	Physiclan/Medlcal	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d 9 ☐ Unknown	Il death 3 □Ectopic pregnand	у	2	3d. Date of delivery Month Day Year
	w requires that been signed b should be deta	by	Part II. Other significant conditions con	tributing to death but not res	ulting in the underlying cause gr	ven in Part I. 2	3e. Did tobacco us	se contribute to the cause of death? No 3 Probably 4 Unknown
Division of Vital Records,	The law rate has be page 2 sh	Completed					4a. Was an autopsy performed? □ Yes 2 V No	24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No
<u> </u>	Physiclan: rthis certific ral director,	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	ospital:	ER/Outpatient 3 DOA	26. Place of Death (Che her: 4 Nursing Home 5		i □Other (Specify)
ion oi	or Attending Physician: The lav after death. Director: After this centificate has in by the funeral director, page 2	Certification;	27. Manner of Death 1 ■Natural 5 □ Pending 2 □ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of 28c. Inju		escribe how injury	
Ω	vital or Attenurs after deating Director:		3 Suicide 6 Could not be determined	building, etc. (Specif	· ·	C	ity or Town, State)	
	To the Hospital within 24 hours a To the Funeral I completely filled	ledical	(Check only 2 Medical Exemin	er: On the basis of examina and manner stated.	owledge, death occurred at the ti	opinion, death occurred at t	he time, date and	place, and due to the cause(s)
	To the vithin 2 To the complete	Σ	29b. Signature and title of certifier	Dr Raul Cha	avez Valæz 29c. Licens	S - 000		a signed (Month, Day, Year)
			30 Name and address of person who cou	moleted cause of death /Item	n 23a) (Type Print)			

State Registrar Raul Chave & Val 31. Date filed (Month, Day, Year) OCT 0 3 2007

			For	State of	Marylan	d / Depa	artment of H	lealth a	nd Mental Hy	giene		
		•	State Registrar			Cer	rtificate of	Death		Reg. No.	107	33167
#	Dhysioi	an.	1. Decedent's Name (First, Middle,	Last)		D	0		2. Date of De Month	eath Day	Year	3. Time of Death
	Physici /Medic	_	Kichard)ale		K	eed			mberz	9 2007	2345 ™
	Examin	er	4a. Facility Name (If not institution,				4b. City, Town, o	_	Death		ty of Death	
			Shady Grove Adv		spital 7. Age (In yrs.	last hirthday)	Rockvil If Under 1 Year		4 Hrs. 8 Date of Bir		gomery 9. Birth	Dlace (State or Foreign
н	Funeral Director		191-50-4603	13 X M 2□F	51	Yrs.	Months Days	Hours	4 Hrs. 8. Date of Bir Min. (Month, Da March 2	iÿ, Year) 6 - 1956	Coui	nsylvania
	- in-		Usual Residence of Decedent						ļ. (4.1 - 1.	0, 2000		
	rylan how Lat	_	10a. State 10b. County		10c. City	y, Town or Lo	cation					10d. Inside City Limits 1 ☐ Yes 2 ☒ No
	se Ma Sa-f s	Directo	Maryland Montgo	mery	Mor	ntgomer	y Villag	e				
	vith th	ä	10e. Street and Number				10f. Zip Code			10g. Citizen o		
	s 23a nust	eral	20230 Grazing W	ay 12. Was Dece	dent Ever in II	S 12 V	2088		in? (Specify Ves or N	United	State ace - Americ	
	ter de iner	Funeral	11. Marital Status 1 □ Never Married 2 ☑ Marrie	Armed For d 1 ☐ Yes	rces? 217 No				in? (Specify Yes or No Puerto Rican, etc.)	В	lack, White,	etc.
980	urs al al', or Exam	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Da	e		1 ☐ Yes 2 🖾 No	Specify:		Spe	oify: Whi	te
5-0036	72 ho natur lical I	Completed	15. Decedent's (Specify only highest			16a. Deced	dent's Usual Occup	ation	of working	16b. Kind of	Business/In	dustry
2121	ithin and "I	nple	Elementary/Secondary (0-12)	College (1-	-4or 5+)	life. L	DO NOT use retired	1)	- · · · · · · · · · · · · · · · · · · ·		*	•
2	be filed within 72 hours after death with the Marylan Ital Hyglene. d other than "natural", or Hems 23a or 28a-f show event, the Medical Examiner must be notified at		17. Father's Name (First, Middle, L	4 4		Grap	hic Desi		's Name (First, Middle	Graphi Maiden Surn		Lgn
anc	ould be filed within 72 hours after death with the Maryland Mental Hyglene. arked other than "natural", or items 23a or 28a-f show artic event, the Medical Examiner must be notified at	Be	John Reed	351)					stal Rebucl		ame)	
Maryland	s 1 and 2 should be if Health and Menta item 27 is marked other traumatic ev	2	19a. Informant's Name/Relationshi	p (Type, Print)		19b. Mailir	ng Address (Street		or Rural Route Numb		n, State, Zij	Code)
	and 2 sho ealth and n 27 is ma		Christine Marie		ouse)	20230) Grazing	Way.	Montgomer	y Villa	ge, M	20886
re,	item 27		20a. Method of Disposition		20b. P	Place of Dispo	sition (Name of matory or other place	i	Date	20c. Locatio		
Ë	Pages ment of I ant: If its ury or o		1 ☐ Burial 2 ☑ Cremation : 4 ☐ Donation 5 ☐ Other (<i>Sp</i>			ropoli	itan Crem	atory	10/01/07	Alexan	dria,	Virginia
Baltimore,	permit. Pages Department of Important: If ii any injury or o		21. Signature of Funeral Service L	iconsee	D .	122	Name and Addre	ss of Facility	DeVol Furk Drive	neral H	ome	
	9 9 E P 9		Y obott A	bklif_		Ga	aithersbu	rg, MI	20877		_	
			23a. /art1. Enter the dilector, or of shock, or heart failure. List of	omplications hat cannot one cause on ea	aused the deat ach line.	h. Do not ent	er the mode of dyi	ng, such as d	cardiac or respiratory	arrest,		Approximate Interval Between Onset and Death
1	Physician		Immediate Cause (Final disease or condition resulting in death)	_a. Acut	le Mi	106980	ial In	fur	fion			minutes
	/Medical Examiner		resulting in dealin)	Due to (or as a conse	(lence of):	1					101100
4		-i	Sequentially list conditions,	b. Due to	r as a conseq	uence of):	101					10 years
7	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events									
6	an an rial-tr	Exa	resulting in death) Last	Due to (or as a conseq	uence of):						
8760	ate be executed hysician and the burial-transit	lical	•	d								
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Box	ath catterd	Physician/Me	23b. Was decedent pregnant in the past 12 months?		irth 2 ∐ Feta ant at time of d	aldeath 3	⊒Ectopic pregnanc ⊒ Other <i>(specify)</i> _	у		23d.	Date of deliv Month	ery Day Year
o.	the de	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□Unkno		ieam 5L						
<u>α</u>	res that the de signed by the a be detached f		Part II. Other significant condition	ns contributing to de	eath but not res	ulting in the u	nderlying cause giv	en in Part I.	23e. Did	tobacco use c	ontribute to	the cause of death?
rds	quires n sign	d by							1	Yes 2 No	3 □ Pro	bably 4 □Unknown
Records,	aw requires s been si	Completed							24a. Was	s an 24	b. Were aut	opsy findings available
m m	The lay	lmo:								ormed?	death?	ompletion of cause of
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	hysic this co	5	1 ☐ Yes 2X No		·	ER/Outpatier	" 3 DOM		sing Home 5 ☐ Res			ify)
) L	ding Ph After th funeral	ion:	27. Manner of Death 1 Natural 5 Pending		of Injury th, Day Year)	28b. Time o Injury	Wo	ryat rk? ∣Yes 2 □ N		how injury oc	curred	
Division or	death ctor: / the	icat	2 ☐ Accident investiga 3 ☐ Suicide 6 ☐ Could no	ot be 280 Place	of injury - At he	ome, farm, str	reet, factory, office	res Z		(Street and Nu	mber or Rui	ral Route Number,
<u>≤</u>	after d after d Direc d in by	Certification:	4 ☐ Homicide determin	buildii	ng, etc. (Speci	fy)			City or To	own, State)		
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit								d place, and due to the th occurred at the time			
	he Ho in 24 I he Fu pletel	Medical	one)	and manr	asis of examina ner stated.	ation and/or in	ivestigation, in my	opinion, deal	th occurred at the time	e, date and pia	e, and due	to the cause(s)
	To t To t	Σ	29b. Signature and title of certifier	1			29c. Licens	se number		29d. Date sig	ned (Month	, Day, Year)
) .	20		1/al E(5	MA		1100	6423	5	septem	Ser 2	9 2007
	,		30. Name and address of person v	vho compléted caus	se of death (Iter	n 23a) (Type,	Print)	n	Rakvill	- m	n -	70850
	Sta	te.	31. Date filed (Month, Dal, Year)	D 9901	legistrar's Signa	ature	anter	Vr. 1	1) accill	- /-//		
	Regist		OCT 02	2007	ر مرونديا	OF SE						

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Dhusisi		Decedent's Name (First, Middle, I	ast)	-					2. Date of Dea	ath Day	Year	3. Time of	Death
Physicia /Medic		JOHN STANLEY REV	ERAND, S	R.					SEPTEMBE		2007	2:45	AM
Examin	er	4a. Facility Name (If not institution, g		mber)			Town, or Location				unty of Deat		
-		322 KEENE FARM L 5. Social Security Number 6	ANE Sex	7. Age (In yrs.	last birthday)		ENSVILLI 1 Year If Und	E der 24 Hrs.	8. Date of Birt		EN ANI	NE'S hplace (State o	r Foreign
Funeral Director		054-05-7919	1 X M 2□F	89		Months	Days Hour	's Min.	8. Date of Birt (Month, Da)	7 . 19	Co	wntry) W YORK	n v orolgn
ms 23a or 28s-f show		Usual Residence of Decedent								.,			
ehow id at	_	10a. State 10b. County		10c. Ci	ty, Town or Lo	cation						10d. Inside Ci	•
28s-f	Director	10e, Street and Number	/EN	S	OUTHBUE	10f. Zir	Code			10a Citizan	of What Co		
la or	٥	HERITAGE VILLAG	E 756 C	ртт т	OD THE		488					*	
od other then "naturel", or items 23s or 28s-1 show event, the Medical Examiner must be notified at	Funeral	11. Marital Status	12. Was Dec	edent Ever in U	I.S. 13.1	Was Dece	dent of Hispanic	Origin? (Sp	ecify Yes or No-			rican Indian,	
min		1 Never Married 2 Married	If Vas Gi	2 🗆 No		ir Yes,spe 1⊡ Yes	cify Cuban, Mexical Company of the Cuban, Mexical Company of the Cuban, Mexical Company of the Cuban, Mexical Company of the Cuban, Mexical Company of the Cuban, Mexical Company of the Cuban, Mexical Company of the Cuban, Mexical Cuban, C		Hican, etc.)	So	Black, White ecity: WE		
Exe	d by	3 XWidowed 4 □ Divorced	Year or L	ates: 1942 -	1946			y.					
adjes	ompleted	15. Decedent's (Specify only highest			(Give	kind of wo	al Occupation ork done during m se retired)	nost of work	ring	16b. Kind	of Business/	Industry	
Mac	duc	Elementary/Secondary (0·12)	College (1-4or 5+)			RESENTA	TTVF		TEXT	TIR TN	DUSTRY	
ent,	C	17. Father's Name (First, Middle, La	st)		DIND	D ICDI			e (First, Middle,			DOSIKI	
Ilc •	ToB	LIONEL REVERAND					ADI	ELIDE	CLAIRMO	NT			
E .		19a. Informant's Name/Relationship	(Type, Print)		19b. Mailir	ng Addres	(Street and Nun	nber or Rur	al Route Numbe	er, City or To	wn, State, 2	(ip Code)	
r other treumatic		STEPHEN REVERAND	/SON	1			FARM LA						666
. 0		20a. Méthod of Disposition 1 ☐ Burial 2 ☐ Cremation 3	☐Removal from		Place of Dispo cemetery, crer	natory or	me of other place)		BER 26	20c. Locat	ion - City or	Town, State	
jury or o		4 ☐ Donation 5 ☐ Other (Spe	city)				EMATORY	_	07			CONNEC	
any injury once.		21. Signal re of uneral Service Lic	ensy		FE	LLOW	AMELIFE	NBEIN	AND NET	WNAM I	UNERA	L HOME,	P.A.
		23a. Part 1. Enter the disease, or co	mplications that of	aused the deal			AMROCK R			-	LLAND	Approximate	
inian		shock, or heart failure. List on Immediate Cause (Final			O A WOED				•			Interval Bet Onset and I	
cian dical		disease or condition resulting in death)	a	REATIC (or as a consec									
iner		Conventially list conditions	b										
Ħ	Iner	Sequentially list conditions, fary, leading to immediate cause. Enter Underlying	Due to	or as a consec	ruanos of):				· · · · · · · · · · · · · · · · · · ·				
the burial-transit	Examin	Cause (Disease or injury that initiated events resulting in death) Last	C. Due to	(04.00.0.00000									
		, , , , , , , , , , , , , , , , , , , ,	Due (o	or as a consec	(uerica or):								
2	dical		d										
989	Physician/Me	IF FEMALE: 23b. Was decedent pregnant		tcome of pregna						23d	. Date of del	iverv	
	cla	in the past 12 months?	4□Pregr	oirth 2 □Feta nant at time of c		Ectopic p Other (s)					Month		rear
	hys	9 Unknown	9□ Unkn	own									
	by P	Part II. Other significant conditions	contributing to d	eath but not res	sulting in the u	nderlying o	ause given in Pa	art I.	23e. Did to	obacco use		the cause of d	
ien en pinnie	ted								101	res 2□N	lo 3∏Pr	obably 4 🗶 l	Jnknown
	ompleted								24a. Was	SV	4b. Were au	topsy findings a	available ause of
pa	Con								perfo	rmed? 2. X No	death?	2 X No	
funeral director, pag	Be	25. Was case referred to medical examiner?	Hospital:				Othor	ace of Deat	h (Check only o	nel		SON*	s
ig d	2	1 ☐ Yes 2 📉 No 27. Manner of Death	Hospital: 1 28a. Date	Inpatient 2	28b. Time of				ome 5 Resid			RESIT	ENCE
d in by the funer	to the	1 XNatural 5 ☐ Pending	(Mon	th, Day Year)	Injury	м	28c. Injury at Work? 1 ☐ Yes 2		200. Describe i	iow injury o	SCUITEG		
y In	flca	3 ☐ Suicide 6 ☐ Could not	be 28e. Place	of Injury - At h	ome, farm, str				28f. Location (S		umber or Ru	ral Route Num	iber,
5	Certification:	4 Homicide	build	ng, etc. (Speci	fy)				City or Tow	vn, State)			
y fille			Physician: To the										
completely filled in by the fu	edical	(Check only 2 Medical Ex	eminer: On the b and man	asis of examina ner stated.	ation and/or in	vestigation	, in my opinion, o	Death occur	red at the time,	date and pla	ice, and due	to the cause(s)
E 00	Σ	29b. Signature and title of certifier	Jusin	1.0	70. 1	29	c. License numbe	er		29d. Date s	igned (Mont	h, Day, Year)	
		• /nome	MUR	esce.	m		D23867			9-23-	-07		
		30. Name and address of person wh		,									
		THOMAS WALSH, M.]				S, ST	EVENSVII	LE, M	ARYLAND	21666	5		
Sta	te	31. Date filed (Month SEY, Year)	32. F	les strar's Sign		1.		و		_ 2100(

07-07361 Jamie Ann Tippe			oe or Print in Bl ate of Maryland	/ Depai		Health ar			ne	20	00.	7 331
Physici		Registrar 1. Decedent's Name (First, Middl	le,Last)	- 001	incate or i	Jealii			te of Death		3	. Time of Death
Medical Exami		JAMIE ANN REDDE	EN					Mo Se	onth ptember	Day Year 20, 2007		1645 hrs
4		4a. Facility Name (if not institution	on, give street and number)	4t	. City, Town, o		of Death		4c. County of		
Euroval		620 Americana Drive 5. Social Security Number		je (In yrs. la:	st hirthday)	Edgewater		er 24Hrs 8 F	hate of Birth	Anne Arui		lace (State or
Funeral Director		578-88-5123 Usual Residence of Decedent	1 M 2 X F	38		Months Da		s Min:			Foreign	ry) MARYLANI
any		10a. State 10b. County		10c. City,	Town or Locatio	n						0d. Inside City Limits
and show	ō	MARYLAND ANNE	ARUNDEL	ANNA	POLIS						1	X Yes 2 No
vith the Maryland 8 23a or 28a-f show a e notified at once.	rector	10e. Street and Number				10f. Zip Code			. 10	g. Citizen of Wha	t Country	n
ith the	al Di	620 AMERICANA I	DRIVE	Constantin	140,144	21403		-1-0 / 016	YN-	UNITED		
death v	Funeral	1 Never Married 2 X M	arried Armed Forces		If Yes		n, Mexican	gin? (Specify n, Puerto Ricar		White,	etc.	n Indian, Black,
urs aff	d by	15. Decedent's Education (Spe	or Dates:	mpleted)	16a. Decedent's	Usual Occupa	ation (Give	kind of work d	one	16b. Kind of Busi		
6 72 ho in "na cat Ex	leted.	Elementary/Secondary (0-12)	College (1-4 or	5+)	during mos	st of working lif	e. DO NOT	use retired)				
DO3(within iene.	ompl	12			BANKER					BANKIN	G	
imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after ment of Health and Montal Hygies attent of Health and Montal Hygies date: In tiem 27 is marked other than "natural", or other traumatic event, the Medical Examiner.	Be C	17. Father's Name (First, Middle, HOWARD E. TIPP)						r's Name (First		laiden Surname)		11.0
212 212 outd'be Ment mark ic ever	To B	19a. Informant's Name/Relations			19b. Mailing	Address (Stre				ber, City or Town,	State, Z	ip Code)
MD 4 2 sho th and a 27 is numati	1	KENNETH REDDEN	HUSBAND					VE, ST	EVENSV	VILLE, M	ARYL	AND 21666
s l and freal friten er tra		20a. Method of Disposition 1 Burial 2 X Cremation	n 3 Removal from St		lace of Dispositi ematory or othe		emetery,	SEPTEMB		20c. Location - C	City or To	wn, State
Page ment c		4 Donation 5 Other S	necify:		ESAPEAKI	CREMA'	TION	200)7	STEVENS	VILL	E, MARYLAN
Baltime permit. Page Department Important: injury or ot		21. Sign tun of Funeral Service	Licensee / I fan	V	FELL	ows Addre	ELFEN	BEIN AN	ID NEV	NAM FUN	ERAL	HOME, P.A
Physician		23a. Part I. Enter the disease, or	complications that caused	the death.						st, shock, or hear		Approximate Interval
/Medical	1 1	failure. List only one cause Immediate Cause (Final disease	0 1 1 111	itoma								Between Onset and Death
(xaminer		or condition resulting in death)	Due to (or as a cons		:		Uto.				\neg	
	. <u>.</u>	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a cons	equence of)							-	
	Examiner	Cause Enter Underlying Cause (Disease or injury that initiated	C									
ited d ansit	Exa	events resulting in death) Last	Due to (or as a cons	equence of)								
execu an and	ical	UNPENDED	amended									
60, ate be shysici	Med	IF FEMALE:	23c. If yes, outco	me of pregn	ancy			-		23d. Date of d	elivery	
of Vital Records, P.O. Box 68760, ing Physician: The law requires that the death certificate be executed After this certificate has been signed by the attending physician and lineral director, page 2 should be detached for use as the burial - transit	sician/Medical	23b. Was decedent pregnant in the past 12 months?	December of	t time of dea	46	I death 3	Ectopi	ic pregnancy		Month	Day	/ Year
Sox death c e atter I for us	ysic	1 Yes 2 No 9 Uni		t time of dea	5 Othe	er (Specify)			_			
O. E at the	/ Phys	Part II. Other significant condit	tions contributing to deat	h but not re	sulting in the un	derlying cause	given in Pa	art I.	23e. Did tot	bacco use contrib	ute to the	cause of death?
s, P.O. iires that th i signed by	d by	Chronic Alcohol Abus	se					L	1 Yes	2 V No 3	Probat	oly 4 Unknown
Division of Vital Records, at lat or Attending Physician: The law require at fact death. After this certificate has been sited in by the funeral director, page 2 should b	Complete								24a. Was a autops	sy pri	or to con	osy findings available apletion of cause of
Rec The la cate ha	om							1	✓ Yes 2		ath? ✔ Yes	2 No
tal F rian: certifi ector,	Be	25. Was case referred to medica examiner?	Hasnital:				T	(Check only o				
f Vi Physi er this	ပို	1 ✓ Yes 2 No 27. Manner of Death	28a. Date of Inju		ER/Outpatient 28b. Time of Inj		Other ₄ ury at Work	Nursing Hor		Residence 6 ow injury occurred		cene
	ion	1 Natural 5 Pend	found: Day,	rear)	FOUND:		Yes 2	- ISubi		and hit head	•	
riSic r Atte ter dea irecto ir by th	Certification:		stigation Sep 20, 2007 28e. Place of Ir		1645 hrs me, farm, street	factory, office	building, et				or Rural	Route Number, City
Div	erti		rmined (Specify) Sir	ngle Fam	ily Home			620	or Town, St Americana	ate) a Drive #206, E	dgewate	er, MD
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be exect within 24 hours after death. To the Faueral Director: After this certificate has been signed by the attending physician an completely filled in by the funeral director, page 2 should be detached for use as the burial - tr	Medical ((0110011 0111)	hysician: To the best of m miner:On the basis of exa and manner stated.	-								
F 3 F 8	Me	29b. Signature and title of certific		-			se number			29d. Date signed		
(2)		Calule	(M)			0.0	.M.E.			September 2	21, 200)7
(0)		30. Name and address of person				Street Poli	imore M	MD 21201				
>6		Laron Locke MD. A	ssistant Medical Ex	annner	111 Penn	oneet, Balt	inore, iv	וט 2 ו 20 ו				

DHMH 17 Rev 1/2001 OCME 2006

Registrar

	1 - State Registrar			Certifica	te of D	Death			Reg. I	No.2	107	331	70
Physician	1. Decedent's Name (First, Middle, Last)							2. Date of I		Day	Year	3. Tirhe of	Death
/Medical	Richard A. Re	Octob					_			03:05	hrs		
Examiner	4a. Facility Name (If not institution	Como	4b. City, Town, or Location of Death Frederick					'		y of Death lerick			
	Northampton 5. Social Security Number		e (In yrs. last b.		r 1 Year	If Under	24 Hrs.	8. Date of E	Birth	rred		place (State o	r Foreign
Funeral Director	579-32-5662 Usual Residence of Decedent		79	Yrs. Months	Days	Hours	Min.	July 3	Jay, Ye.	ľ928	Cour	ngton,	
yland iow	10a. State 10b. County		7.	wn or Location							1	0d. Inside Cit	
a-f sh iffed	Maryland Fred	erick	Walk	ersville								XX Yes	2 □ No
hours after death with the Maryland hours after death with the Maryland tural", or items 23a or 28a-f show at Examiner must be notified at at by Funeral Director	10e. Street and Number 121 Phoenix Co		10f. Z	p Code 2179	3			10g. Citizen of What Country? USA					
fter death v	11. Marital Status	11. Marital Status 12. Was Decedent Ever in U.S.					igin? (Spe	ecify Yes or I Rican, etc.)	No-		ce - Americ		
ours after derail, or iten	1 Never Married 2 Married 1 Tyes 2 No If Yes, Give			If Yes, sp		n, Mexicai Specify:		Rican, etc.)		Speci	ick, White,	etc. hite	
ural"; o	3 XWidowed 4 ☐ Divorced	Year or Dates:				, ,				1	.,.		
ed within 72 horygiene. Per than "natur. It, the Medical E	(Specify only highe	it's Education est grade completed)		a. Decedent's Usi (Give kind of w life. DO NOT I	ial Occupa ork done d ise retired)	ition <i>uring mos</i> I	st of work	ing	16b.	. Kind of E	Business/In	dustry	
withi iene. than the M	Elementary/Secondary (0-12)	College (1-4or 5	, I —	Testman					Telephone			Compan	ı y
be filed tal Hyg d other event, I	17. Father's Name (First, Middle,	Last)				18. Mothe	er's Name	e (First, Midd					
Menta Menta arked atic ev	Thomas Burt	on Reid				E	liza	beth H	olme	es			
nd 2 sho alth and I 27 is ma	19a. Informant's Name/Relations Kathleen Via –		1	b. Mailing Addres						-		,	702
permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any Injury or other traumatic event, the Medical once. To Be Completed	20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (5		cemet	of Disposition (Na ery, crematory or Cemeter	other place	9)		Date -2007			- City or To	own, State	land
ortme Sortme Injur	21. Signature of Funeral Service		//10	22. Name a	nd Addres	s of Facili	ty St	auffer	Fur	nera1	Home		
on on per	Sharow (i	anille G	eline	1621 0	possu	mtow							1702
TELES .	23a. Part1. Enter the disease, or shock, or heart failure. List	r complications that caused only one cause on each li	the death. Do	not enter the mo	de of dying	g, such as	cardiac	or respiratory	arrest,			Approximate Interval Bet	ween
Physician	Immediate Cause (Final disease or condition		1 .	son is	^							Onset and E	
/Medical Examiner	resulting in death)		a consequence				./.						
and the	Sequentially list conditions,	b	16111	ar	uge	ner	a Ti	m				45	
nine	cause. Enter Underlying Cause (Disease or injury	a consequence	allar degeneration										
certificate be executed ding physician and se as the burial-transit	that initiated events resulting in death) Last	e of):											
icate be exphysician is the burian		d											
certificate be ding physicis se as the bu													
	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome 1 ☐ Live birth		th 3⊟Ectopic;	regnancy						ate of delive		/nor
The law requires that the death of the law requires that the death of the atten bage 2 should be detached for unonpleted by Physician	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at 9□Unknown	t time of death	5 ☐ Other (s	pecify)					IV	lonth	Day Y	/ear
hat the ded by Jetacl	Part II. Other significant conditi	ons contributing to death b	out not resulting	in the underlying	cause give	n in Part I	l.	23e. Die	d tobacc	o use cor	ntribute to th	he cause of d	eath?
signe d be c		•							Yes	2 No		ably 4 □L	
: The law requi					• •			24a. Wa	as an	24h	Were auto	psy findings a	available
he lav e has age 2 :								au pe	topsy rformed	?	prior to condeath?	mpletion of ca	ause of
	25. Was case referred to medica	ıl İ				26. Place	e of Deat	1 Yes h (Check onl)		No	1 ☐ Yes	2□No	_
hysici this cer al direc	examiner? 1 ☐ Yes 2 No	Hospital: 1 ☐ Inpatie	ent 2 ☐ ER/O	Outpatient 3 D	OA Othe	r 🗸		me 5□Re		6 🗆 🔾	her (Specit	'v)	
ng Ph fter th neral	27. Manner of Death 1 Natural 5 □ Pendir	28a. Date of Inju (Month, Da	ry 28b.	Time of Injury	28c. Injury Work	at ?		28d. Describ	e how ir	njury occu	rred		
tendine eath. or: A the fu	2 Accident investi	gation		М	1 🗆 Y	′es 2□	No						
Ital or Attending F rs after death. ral Director: After led in by the funers Certification:	4 Homicide determ	ained Zoe. Place of III)	ury - At home, f cc. <i>(Specify)</i>	farm, street, facto	ry, office			28f. Location City or 7	Street own, St	and Num ate)	ber or Rura	al Route Num	ber,
	29a. Certifier 1 Certifyi	ng Physician: To the best	of my knowledg	e. death occurre	d at the tim	ne date a	nd place	and due to th	ne Calles	e(s) and n	nanner as s	tated	
the Hosp ithin 24 hou the Fune ompletely fi		Examiner: On the basis o and manner sta	of examination a)
To th To th comp	29b. Signature and title of certifie	2 0		29	c. License		_		29d. I	Date sign	ed (Month,	Day, Year)	
	1 / Nex	white in			D3	105	58		Oc	tobe	r 2,	2007	
3	30. Name and address of person								_				
	Gene Ashe, M.D			ine Road		dsbo	ro, l	Maryla	nd	2179	8		
State Registrar	31. Date filed (Month, Day, Year)	3 2007 32. Registr	ars Signature	food	1								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

			1 - State Registrar	aryland / Depa	rtificate of L		Reg	ene2007	33171								
. Physician /Medical Examiner			1. Decedent's Name (First, Middle, Last) Edgar M	ilton Rolli	son Jr.		2. Date of Death Month October	Day 2007 Pear	3. Time of Death 8:36 P M								
			4a. Facility Name (If not institution, give street and number) Kline Hospice House		4b. City, Town, or Mt. Air	Location of Death		4c. County of Death Frederick									
26.	Funeral Director		217-30-7380 1 [™] M 2□ F	ge (In yrs. last birthday) 72 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,) May 19,	Q Right	place (State or Foreign ntry) cyland								
	Maryland a-f show ified at	tor	Usual Residence of Decedent 10a. State MD Frederick	10c. City, Town or Lo				1	10d. Inside City Limits 1								
	th with the 23a or 28 ist be not	Funeral Director	10e. Street and Number 3510 Cemetery Circle		10f. Zip Code 21758	3	100	g. Citizen of What Cour USA	ntry?								
980	be filed within 72 hours after death with the Maryland tal Hygiene. d other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at	by	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Armed Forces 1 Never Married 11. Was Decedent Armed Forces 1 Yes, Give Year or Dates:	No I	Was Decedent of Hi If Yes, specify Cuba 1 □ Yes 2🛣 No	spanic Origin? (Spin, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White, Specify: Whi	etc.								
21215-0036	within 72 ho ene. than "natui he Medical	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or	(Give	dent's Usual Occupa kind of work done o DO NOT use retired	ation during most of work)	ing	6b. Kind of Business/In									
Maryland 2		To Be Co	17. Father's Name (First, Middle, Last) Edgar Milton Rollison Si				e (First, Middle, Ma ay Piper		Birmay								
	d2sh thand 7Ism traum		19a. Informant's Name/Relationship (Type. Print) Carl L. Rollison - Son	19b. Mailin 116	ng Address <i>(Street a</i> Bailey Ci	and Number or Rur rcle - Fa	al Route Number, o	City or Town, State, Zip WV 26554	Code)								
Baltimore,	8 4 1		20a. Method of Disposition 1 Burial 2 Tremation 3 Removal from State 4 Donation 5 Other (Specify)	20b. Place of Disposementery, crem Hagersto	sition (Name of matory or other place wn Cremat			Oc. Location - City or To									
Balt	permit. Page Department of Important: If any injury or once.	0 (0	21. Signature of Fund Service Licensee	22	2. Name and Addres	301		liams Fune MD 21716	ral Home								
	Physician /Medical Examiner Sequentially list conditions, if any, leading to immediate dause. Line of line of the interest of								Approximate Interval Between Onset and Death								
Box 68760,	leath certificate be executed attending physician and for use as the burial-transit	ledical	ledical	ledical	edical	ledical	ledical	ledical	edical	edical	d	2 ☐ Fetal death 3 ☐	∃Ectopic pregnancy			23d. Date of delive	ery Day Year
P.0.	The law requires that the death cer the has been signed by the attendin age 2 should be detached for use	Physician/M	1 ☐ Yes 2 ☐ No 9 ☐ Unknown Part II. Other significant conditions contributing to death be		Other (specify)	en in Part I.	23e. Did toba	cco use contribute to the									
Records,	w requires been signe should be	eted by					1 ☐ Yes	2 No 3 Prob	bably 4 Unknown								
Vital Rec	10 1	e Completed	25. Was case referred to medical			26 Place of Death	24a. Was an autopsy performe 1 Yes 2	prior to co	opsy findings available impletion of cause of								
o	arth. rr: After this or funeral dir	ation: To Be	examiner? 1 Yes 2 No Hospital: 1 Inpatit 27. Manner of Death 1 Natural 5 Pending (Month, De	ry 28b. Time of	28c. Injury Work	er: 4 🗆 Nursing Ho	me 5 Residen	ce 6 Other (Specif	the hospice								
Division	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the f	Certification:	3 Suicide 6 Could not be 4 Homicide determined 28e. Place of in building, ei	ury - At home, farm, stre c. <i>(Specify)</i>	eet, factory, office		28f. Location (Stre City or Town,	et and Number or Rura State)	al Route Number,								
	the Hosp in 24 hou the Fune ppletely fil	Medical	29a. Certifier (Check anly one) 1 Sertifying Physician: To the best 2 Medical Examiner: On the basis of and manner st	f examination and/or inv	vestigation, in my o	pinion, death occur	and due to the cau red at the time, dat	se(s) and manner as s e and place, and due to	itated. o the cause(s)								
	To 1 To 1	2	29b. Signature and tive of certifier	sesur	29c. License	os (25 o 0 o 0 o 0 o 0 o 0 o 0 o 0 o 0 o 0 o	290	I. Date signed (Month,	_								
-	9		30. Name and address of person who completed cause of o		elo 9	Th Ave	I sure	Kingnis E	Cm,								
	Sta Registr	-	31. Date filed (Month, Day, Year) 32. Degistr	ar's Signature	and I				21716								

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Day Year THOMAS WORTHINGTON 9 RUARK 24 /Medical 2007 11:20P 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BERLIN NURSING & REHABILITATION CTR. BERLIN

1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) WORCESTER 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1X M 2□F Months 87 Director 215-05-6286 20, FEB. 1920 MARYLAND Usual Residence of Decedent 10a. State 10c. City, Town or Location show 10b. County 10d. Inside City Limits at r than "natural", or items 23a or 28a-f shifted the Medical Examiner must be notified 1 Yes 2 □ No Director MARYLAND WORCESTER OCEAN CITY 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 14420 WIGHT SANDS 21842 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. 11. Marital Status Black, White, etc. 1 X Yes 2 □ No If Yes, Give Year or Dates: WWII 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. þ Specify: 3 X Widowed 4 ☐ Divorced WHITE Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) filed withir I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) US AIR FORCE MAJOR Department of Health and Mental Hygie Important: If item 27 is marked other it any injury or other traumatic event, th once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be UNKNOWN ပ GRACIE CANNON 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) RONALD RUARK/SON 1503 SHADYSIDE RD., BALTIMORE, MARYLAND 21218 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 ☐Removal from State 4 □ Donation 5 □ Other (Specify) CREMATORY OF DELMARVA 9/26/07 DELMAR, DELAWARE permit. 22. Name and Address of Facility HASTINGS FUNERAL HOME, SELBYVILLE, DE. 19975 Palt. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. eath. Do not enter the mode of dying, such as cardiac or respiratory arrest Immediate Cause (Final disease or condition resulting in death) **Physician** tastatie /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) be executed Due to (or as a consequence of): burial-Box 68760 physician Physician/Medical the as attending properties for use as IF FEMALE: yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day □Pregnant at time of death 5 Other (specify) P.O. ed by the a 9□Unknown 9 Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s certificate has autopsy perform 1 ☐ Yes 2 No Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner Other: 20 No 1 Tes 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 27. Manner of Death 28a. Date of Injury 28b. Time of After t 28d. Describe how injury occurred 28c. Injury at Work? Hospital or Attending 5 ☐ Pending investigation (Month, Day Year) 1 Natural 2 Accident Injury 1 ☐ Yes 2 ☐ No 24 hours after death Funeral Director: 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

— Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only one and manner stated. within 24 29c. License number Signaty 2 29d. Date signed (Month, Day, Year) AVI person who completed cause of death (Item 23a) (Type, Print) gistrar's Signature State 2007 Registrar

DHMH 17 Rev 1/2001

Ruark, Thomas

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State Amended 10/10/07, item#11,s1u WCHD ate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month September Dav **Physician** 2007 0411 PHILLIP RCBINSON /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death . **Examiner** Peninsula Regional Medical NICOM 100 Center 301155414 If Under 1 Year | If Under 24 Hrs Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 M 2 □ F Director 220-32-1464 11-2-36 MARYLAND Usual Residence of Decedent death with the Maryland 10b. County r 28a-f show notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits 1,∏Yes 2∏No Directo WICOMICO CO SALISBURY 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? ", or items 23a or 2 401 TRINITY DRIVE Funeral 21801 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Examiner Black, White, etc. 1 Never Married 2 Married 3 Widowed 4 Divorced 1 Yes 2 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. Specify: BLACK Completed by Pages 1 and 2 should be filed within 72 hours and to Health and Mental Hygiene.
ant: If Item 27 is marked other than "natural"; (permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical.) once. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) TRUCK DRIVER 11 WASTE SERVICES 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ LEVIN ROBINSON SR. LOLA PRICE 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 28606 OCEAN GATEWAY SALISBURY MD 21801 HOWARD ROBINSON BROTHER 20b. Place of Disposition (Name of cemetery, crematory or other place)
ST. JAMES METH. CEM. 20a. Method of Disposition Date 20c. Location - City or Town, State 10-01-07 QUANTICO, MD 1. Signature 22. Name and Address of Facility BENNIE SMITH FUNERAL HOME 917 W. ISABELLA ST. SALISBURY, MARYLAND 21801 23a. Part1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner ROIDMYODAL Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner neu monin and Due to (or as a consequence of): nding physician The law requires that the death certificate be Physician/Medical use as the IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant atte 3 ☐Ectopic pregnancy in the past 12 months? Month Year Dav 5 Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 ✓ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a, Was an certificate has perform 1□ Yes 2 No 25. Was case referred to or ical examiner? Be 26. Place of Death Check onl one Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 1 Hnpatient 2 ER/Outpatient 3 DOA P this 28a. Date of Injury 27. Manner of Death 1 Natural 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After (Month, Day Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No heral Director: 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Division or Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: within 24 hours a To the Funeral I

> State Registrar

Medical

29a. Certifier

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month Sex.)

30. Name and address of

death (Item 23a) (Type, Print)

RAFFETTO MD

completed cause

200

Soseph KA++c...

S2. Registrar's Signature

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of mamination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manifer stated.

29c. License number

1)20441

29d. Date signed (Month, Day, Year)

1008 CAPROLL St. SAlisbury, Md. 21801

SEPT. 28, 2007

ario Pineda	State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No. 2007 33	17
Physician/	1. Decedent's Name (First, Middle,Last) 2. Date of Death Mouth Day Year	1
ledical Examiner	4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death	-
,	Fort Washington Hospital Fort Washington Prince George's	
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) None 7. Age (In yrs. last birthday) 7. Age (In yrs. last birthday) Yrs. 1 None 7. Age (In yrs. last birthday) Yrs. 1 None 1 None 7. Age (In yrs. last birthday) Yrs. 1 None 1 N	ıs
any	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City	Limits
*	Maryland Prince George's Temple Hills	X No
with the Maryland ns 23a or 28a-f sho be notified at once.		
er death , or iten Fune	Wildowed 4 Divorced If Yes Give Year 1 Yes 2 No specify Honduran Specify White	ς,
ours after a stranger a series a series a series de la by	15 December 5 Februaries (Specifically inspect acide completed) 15a December's Liquid Occupation (Give kind of work done 16b Kind of Business/Industry	
5-0036 ed within 72 hour lygiene. other than "natt the Medical Exan	Elementary/Secondary (0-12) College (1-4 or 5+) Construction Worker Construction	
215-0036 be filed within 7 minal Hygiene. riked other than ent, the Medica Be Comple		
212 ould be I Menta s marko ic even		
MD and 2 sho alth and 2 sho alth and 57 is raumati	Concepcion Ortiz/Sister 2360 Ashford Lane, Waldorf, MD 20603 20a Method of Disposition 20b Place of Disposition (Name of cemetery, Date 20c Location - City or Town, State	
Baltimore, permit, Pages 1 ar Department of Hee Important: If ite	1 X Burial 2 Cremation 3 X Removal from State Vista Memorial Gardens October 7 Miami, Florida	
Balti permit. Departi Import injury	21. Signature of Funeral Service Licensee 22. Name and Addrass of Collins Funeral Home Inc. 500 University Blvd, W, Silver Spring, MD 20	0001
Physician	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Between Ons	Interval
Medical xaminer	Immediate Cause (Final disease or condition resulting in death) a Due to (or as a consequence of):	
Į.	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):	
ed sit	cause. Enter Underlying Cause (Unsease or injury maximitated events resulting in death) Last Due to (or as a consequence of):	
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c 687(certifica ending pl use as the	FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 2 Fetal death 3 Ectopic pregnancy Month Day Yes Pregnant at time of death 5 Other (Specify)	ear
J. Boy t the death by the att ached for Physi	1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death but not resulting in the underlying cause given in Part I.	ath?
P.O. es that the signed by be detach	1 Yes 2 ✓ No 3 Probably 4 Uni	known
of Vital Records, P.C ng Physician: The law requires that ther this certificate has been signed the metal director, page 2 should be detained. To Be Completed by	24a. Was an autopsy prior to completion of ca performed?	use of
	The second second to medical the second seco	No
of Vital I ing Physician: After this certifity ineral director, uneral director, unit To Be (examiner? O 1 Ves 2 No Hospital: 1 Inpatient 2 VER/Outpatient 3 DOA Other 1 Nursing Home 5 Residence 6 Other:	
n of ding Ph. h. After t	1 2/, Manner of Death 1288, Date of Injury 1266, Title of Injury 1266, Injury at Work: 1266, Describe new Injury Cooking	
Division of Vital pital or Attending Physician: ours after death. leral Director: After this certifilled in by the funeral director, Certification: To Be (2 X Accident Investigation 3 Suicide 6 Could not be determined (Court Investigation 1) 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number or Town, State) 28f. Location (Street and Number or Rural Route Number or Town, State)	er, City
8 4 E >		
To the within To the comple	Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)	
2	Janha Jery MD O.C.M.E. October 1, 2007	
	30. Name and address of person who completed cause of death (Item 23a) Tasha Greenberg MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	
State Registra	E1(1) F 1 / / / PFA A	*

07-07828 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Emil Roushdy State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar Reg. No 1. Decedent's Name (First, Middle,Last) Physician/ 2. Date of Death October 7, Day **Medical Examiner** 0800 hrs Emil Samir Roushdy 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Washington Adventist Hospital Takoma Park Montgomery **Funeral** 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign Days Min. Months Hours Director 216-90-9658 57 Sept. 18,1950 1 X M 2 F Egypt Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits or items 23a or 28a-f show must be notified at once, Yes 2 X No MD Montgomery Bethesda Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code death with the 20817 7605 Royal Dominion Drive United States Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, 1 Never Married 2 X Married Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 2 X No Yes If Yes, Give Year White 3 Widowed 4 Divorced Yes 2 X No specify: Specify: \$ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 6b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) permit. Pages I and 2 should be filed within 72 P Department of Health and Mental Hygiene. Important: If iten 27 is marked other than "r injury or other traumatic event, the Medical E College (1-4 or 5+) 21215-0036 5+Physician Medical 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be Louisa Fahim Samir Roushdy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) B 7605 Royal Dominion Drive Bethesda, MD 20817 Mary Roushdy (Wife) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery Date 20c. Location - City or Town, State crematory or other place) Oct. 1 XBurial 2 Cremation 3 Removal from State 11 Gate of Heaven 2007 Silver Spring, MD Donation 5 Other Specify: 22. Name and Address of Facility DeVol Funeral Home 21. Signature of Funeral Service Licensee A. STUVEK) IRACI 10 East Deer Park Drive Gaithersburg, MD 20877 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** failure. List only one cause on each line. Between Onset and /Medical Death Quetiapine, zolpidem, and lamotrigine intoxication Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, If any leading to immediate cause. Enter Underlying Cause Due to for as a consequence off. Examiner (Disease or injury that initiated death certificate be execute Due to (or as a consequence of): events resulting in death) Last and transit Physician/Medical X UNPENDED ^\mu_23a,27,28a-f, perME,g873, 11/2/07 TT Box 68760, IE EEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth Ectopic pregnancy Month Year Fetal death Day past 12 months Pregnant at time of death Other (Specify) 1 Yes 2 No 9 Unknown Unknown Records, P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Yes 2 No 3 Probably 4 🗸 Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of has performed? death? certificate ✔ Yes 2 2 No No 1 🗸 Yes the Hospital or Attending Physician: 25. Was case referred to medical of Vital 26.Place of Death (Check only one) Be examiner? Hospital: Other₄ Inpatient 2 V ER/Outpatient 3 Nursing Home 5 Residence 6 DOA 1 Yes After this ို 27. Manner of Death 28a. Date of Injury (Month, Day, Year 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Division Natural n 24 hours after death. e Finneral Director: letely filled in by the f Yes 2 X No aubject ingested pills Pending Fnd 10/7/2007 Fnd 7:00 am 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 X Suicide Could not be 4321 Woodberry St. University Park, determined (Specify) House 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Registra DHMH 17 Rev 1/2001

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within 24 To the F

To 1

Medical

State

29b. Signature and title of certifier

Ana Rubio MD

and manner stated

Assistant Medical Examiner

egistrar's Signat

RELIE

30. Name and address of person who completed cause of death (Item 23a)

200

2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

111 Penn Street, Baltimore, MD 21201

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

October 8, 2007

			_ State	ate of Ma	-	epartment o		and Mer		ene			
E	Physici	2	Registrar 1. Decedent's Name (First, Middle, Last)	LISA	SAC				Date of Death Month	Day O	07 Year 7	3. Time of Peaul 6	
	/Medic		4a. Facility Name (If not institution, give stree	t and number)	0/10		, or Location o	of Death	10	4c. Coun	ity of Death	7 - 70	
	- Zamini		4921 Bonniewood	Drive		Shad	Side			Ann	e Aru		
	Funeral Director		5. Social Security Number 6. Sex 1 ☐ M	7. Age	(In yrs. last birt	Months Da		Min.	Date of Birth (Month, Day, 1911)		9. Birthpl Count Mary		
	w	}	Usual Residence of Decedent 10a, State 10b, County		10c. City, Town	or Location					10	Od. Inside City Limits	
	Maryl f sho ied at	힏	MD Anne Arunde	1		Shady	Side					1 ☐Yes 2 X No	
	r 28a	Director	10e. Street and Number			10f. Zip Cod	е		10	g. Citizen o	f What Coun	try?	
	th with	a a	4921 Bonniewood D	rive		20	764			US			
စ္တ	s 1 and 2 should be filed within 72 hours after death with the Maryland I Health and Mental Hygiene. Item 27 Is marked other than "natural", or items 23a or 23a-f show other traumatic event, the Medical Examiner must be notified at	by Funeral	1 □ Never Married 2 Married	Vas Decedent En Armed Forces? I ☐ Yes 2 💆 No f Yes, Give	ver in U.S.	13. Was Decedent If Yes, specify 1 □ Yes 2		gin? (Specify n, Puerto Rica	/ Yes or No- an, etc.)		ace - America lack, White, e	etc.	
21215-0036	hours tural"	q pe	3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education	ear or Dates:	16a.	Decedent's Usual O	cupation		T 1	6b. Kind of	Whi Business/Ind		
7	in 72 n "na Medic	Completed	(Specify only highest grade cor		<u> </u>	(Give kind of work de life. DO NOT use re	ne during mos: ired)	t of working	Ï				
212	d within giene.	ĕ	Elementary/Secondary (0-12)	4	″ c∈	ertified	publi	c acc	counta	nt	acco	unting	
	be filed tal Hygie d other event, the	Be C	17. Father's Name (First, Middle, Last)						irst, Middle, M		ame)		
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Maryland	12 sh sh and 7 Is m traum		19a. Informant's Name/Relationship (Type. I			. Mailing Address (St 21 Bonnie				-			
	of Health item 27 other tr		Jeffrey E. Sachs, sp 20a. Method of Disposition	ouse		Disposition (Name or other		Date			n - City or To		
JOI L	ages ent of it; If it		1 ☑ Burial 2 ☐ Cremation 3 ☐ Remo	oval from State	1	dy of Sor:	1	10_11_	-2007	West '	River.	MD	
Baltimore,	permit. Pages 1 Department of H Important: If ite any injury or ot		21. Signature of Funeral Service Licensee	Same	our ha	22. Name and A 8325 Mt	dress of Facilit	ty Raus	ch Fun	eral :	Home,	P.A.	
	7		23a. Part1. Enter the disease, or complication shock, or heart failure. List only one care	ons that caused i	the death. Do r							Approximate Interval Between	
	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	M	ETA ST	TATIC I	1EL A	NOMI	4			Onset and Death	
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8760,	ate be executed ohysician and the burial-transit		d										
9	entifica ding ph	Med	IF FEMALE:	If yes outcome r	of pregnancy					224	Date of delive	AD.	
P.O. Box	the death certifica / the attending ph ched for use as t	Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1						эу			23d. Date of delivery Month Day Year	
	The law requires that the death certificate be executed the has been signed by the attending physician and page 2 should be detached for use as the burial-transit	by	Part II. Other significant conditions contrib	n the underlying caus	erlying cause given in Part I. 23e. Did tobar 1 ☐ Yes				cco use contribute to the cause of death?				
or Vital Records,		Completed							24a. Was ar autopsy perform 1 Yes 2	24 DNo	b. Were auto prior to co death? 1 Yes	psy findings available mpletion of cause of	
Vita	Physician: Th r this certificate ral director, pag	Be	25. Was case referred to medical examiner?	nital:			Othor:		Check onl one				
or	Phys this ral dir	은 ::	I Yes Sino	1 ☐ Inpatier 28a. Date of Injur		tpatient 3 DOA Time of 28c.	4 □ Nu Injury at	ursing Home 28d	5 Reside		Other (Specificurred	y)	
on	ding h h. After funer	tion	Natural 5 Pending	(Month, Day		njury M	Work? 1 ⊟ Yes 2 ⊟			,,			
Division	Hospital or Attending 4 hours after death. Funeral Director: After tely filled in by the funer	Certification	2 Accident investigation 3 Suicide 3 Suicide 4 Homicide								ımber or Rura	al Route Number,	
	To the Hospital or within 24 hours after To the Funeral Directory filled in b	Medical C	29a. Certifier (Check only one) Certifying Physicial Examiner:	an: To the best of On the basis of and manner sta	examination ar	e, death occurred at nd/or investigation, in	ne time, date a my opinion, de	nd place, and eath occurred	d due to the ca l at the time, da	use(s) and ate and pla	l manner as s ce, and due t	tated. o the cause(s)	
	To the within 2 To the complete	M	29b. Signature and title of certifier Holly Dush	Ken, M	1D		bense number	35		10	9/9/0	7	
	10		30. Name and address of person who comp The property of the person who comp 31. Date filed (Month, Day, Year) OCT 1 6 2007	leted cause of de	eath (Item 23a)	POUS ON	OLOGY	CENT POLIS.	FR 90	0 BE	STEATT	RD, STER	
	St Regist	ate rar	31. Date filed (<i>Month</i> , <i>Day</i> , <i>Year</i>) 0CT 1 6 2007	32. Registra	rs Signature	bado	Minarl	[- 1-1			

			For	Department of Health and M Certificate of Death	Reg. N	2001 33111
	Physicia /Medic		1. Decedent's Name (First, Middle, Last) Dennis A. Stone		2. Date of Death Month D 9/22/07	Oay Year 3. Time of Death 1:38p M
	Examin	er	4a. Facility Name (If not institution, give street and number) Fort Washington Hospital	4b. City, Town, or Location of Death Fort Washingto	n F	c County of Death Prince Georges
	Funeral Director		5. Social Security Number 578-64-3687 G. Sex 1 M 2 F 7. Age (In yrs. last bird) 62	hday) if Under 1 Year If Under 24 Hrs. Months Days Hours Min.	Month, Day, Yea	9. Birthplece (State or Foreign Country) 45 Washington DC
	Maryland -f show	tor	10a. State 10b. County 10c. City, Town MD Prince Georges Fort V			10d. Inside City Limits 1 ☐ Yes ②☐ No
	or 28e	Funeral Director	10e. Street and Number	10f. Zip Code	10g. (Citizen of What Country?
	s 23e	rail	9901 Marina Court 11 Marital Status 12. Was Decedent Ever in U.S.	20744	ecify Yes or No-	USA 14. Race - American Indian,
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Department of Health and Mental Hyglene. Importent: If item 27 is marked other then "natural", or Items 23e or 28e-f show importent: If item 27 is marked other then "natural", or Items 20e or 28e-f show appringing or other treumstic event, the Medical Examination must be notified at an once.	by Fune	11. Marital Status 1 □ Never Married 2 ▼ Married 1 □ Never Married 2 ▼ Married 1 □ Never Married 2 ▼ Married 1 □ Yes 2 □ No If Yes, Give Year or Daties:	13. Was Decedent of Hispanic Origin? (Sprif Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ☒ No Specify:	Rican, etc.)	Black, White, etc. Specify: black
Maryland 21215-0036	nin 72 hou n "natura Medical E	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired)	16b.	Kind of Business/Industry instruments
2	ed with	Com	4 V	iolinist maker/re	pairer e (First, Middle, Maid	
and	d be fil ntal H ed ott	Be	17. Father's Name (First, Middle, Last)	Grace		en Sumame)
ary	should and Me a mark umatic	၉	Charles L. Stone 19a. Informant's Name/Relationship (Type, Print) 19b	. Mailing Address (Street and Number or Rura	al Route Number, Cit	y or Town, State, Zip Code)
Ž	and 2 ealth a m 27 ls		Gwendolyn Stone/wife 99	901 Marina Ct. Ft	. Washin	gton, MD 20744 Location - City or Town, State
Jore	ages 1 nt of H : If ite.			Disposition (Name of y, crematory or other place) ngton Cemetery 10-		Clington, VA
Baltimore,	permit. P. Departme Importent any injury once.		21. Sgn ture of Funeral Service Licensee	22. Name and Address of Facility BK Henry Funeral	4	20 H St. NE
			23a. Part1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause greath line.			Approximate Interval Between
	Physician /Medical		M	Infuction of:		Onset and Death
	Examiner					
	led Isit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	of):		
,092	ate be executed hysician and the burial-transit	cal Exar	that initiated events resulting in death) Last C. Due to (or as a consequence	of):		
89	tificate ig phys as the		d.			
.O. Box	that the death certifica ed by the attending ph detached for use as tt	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 Ectopic pregnancy 5 Other (specify)		23d. Date of delivery Month Day Year
٥.	The law requires that the tee bas been signed by thogge 2 should be detache	þ	Part II. Other significant conditions contributing to death but not resulting is	n the underlying cause given in Part I.	23e. Did tobacc	co use contribute to the cause of death? 2 No 3 Probably 4 Unknown
of Vital Records,	hysicien: The law rec his certificate has bee I director, page 2 shou	Completed			24a. Was an autopsy performed 1 Yes 2 1	
/ital	cien: ertifica actor, p	Be C	25. Was case referred to medical examiner?	Other	h Check onl one	
o	Physicien: this certific ral director,	. To	1 ☐ Yes 22 ► 16	Time of 28c. Injury at	ome 5 Residence 28d. Describe how in	e 6 Other (Specify) njury occurred
lon	Attending r death. ector: After by the fune	atlon	1 Matural 5 ☐ Pending (Month, Day Year) 2 ☐ Accident investigation	Injury Work? M 1 ☐ Yes 2 ☐ No		
Division	i Site	Certification;	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, for building, etc. (Specify)	arm, street, factory, office	28f. Location (Stree City or Town, S	t and Number or Rural Route Number, tate)
7	한 구 교 등	edical (29a. Certifier (Check only one) 1 Certifying Physicien: To the best of my knowledg 2 Medicel Exeminer: On the basis of examination are and manner stated.	e, death occurred at the time, date and place, id/or investigation, in my opinion, death occur	red at the time, date	and place, and due to the cause(s)
21	To the within 2.	Me	29b. Signature and title of certifier Aug Manne (Aug M)	29c. License number	29d.	Date signed (Month, Day, Year)
2-	(10)		30. Name and address of person who completed cause of death (Item 23a) Av / v / v / v / v / v / v / v / v / v /	(Type, Print) Livingston Rd, For	t Value	to my 20764
	St Regist	ate rar	OCT 0 2 2007 &	R)		

State of Maryland / Department of Health and Mental Hygiene 🤈 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 27 <u>Day</u> 7 Physician 11:45 Pm STROUD WILLIAM Η. /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** ROCKVILLE MONTGOMERY CASEY HOUSE If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Year) 7–16–61 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours XXM 2□F LANDOVER, MD 579-88-7638 Yrs 46 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 1 X Yes 2 □ No Director PRINCE GEORGE HYATTSVILLE MD 10g. Citizen of What Country? 10e, Street and Number 10f. Zip Code "natural", or Items 23a or dical Examiner must be 2001 WOODREEVE ROAD 20782 U. S. A. Funeral 12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No Specify Specify: þ 3 Widowed 4 Divorced BLACK Completed Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12TH GRADE College (1-4or 5+) 1 MANAGER KFC 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be fill iment of Health and Mental Hiant: If item 27 Is marked oth Be JAMES LOMAX STROUD, SR. VIVIAN ELAINE WALKER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10600 BROAD LEAF DR. UPPER MARLBORO, MD 20774 PATRICIA S. AMERICA / SISTER permit. Pages 1 and Department of Health Important: If item 27 any injury or other tr once. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) HARMONY MEMO. PARK 10-3-07 LANDOVER. MD 22. Name and Address of Facility PINCKNEY-SPANGLER F. R. Funeral Service Licensee 524 - 8TH ST., N. E. WASH., DC 20002-5236 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line. ot enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) **Physician** GASTROINTESTINAL CANCER - METASTATIC /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a sonsequence of): Examiner requires that the death certificate be executed sician and burial-tran Due to (or as a consequence of) Box 68760, physician Physician/Medical the as attending for use as 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Dav in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No ed by the detached Division or Vital Records, P.O. 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by RENAL FAILURE 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an page 2 autopsy performed' certificate 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 The (Specify) HOSPICE Hospital: 1 ☐ Yes 2 🛣 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 this 27. Manner of Death 1 ANatural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? To the Hospital or Attending Provithin 24 hours after death.

To the Funeral Director: After the completely filled in by the funeral I Director: After to d in by the funeral 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 🕅 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0064615 9-28-07 10 20 we and address of person who completed cause of death (Item 23a) (Type, Print)
N WROBLEWSKI, MD 6001 MUNCASTER MI 6001 MUNCASTER MILL ROAD ROCKVILLE, MD 20855 31. Date filed (Month, Day, Year) a32. Registrar's Signature State OCT 0 2 2007 Registrar

		•	For State Registrar	State of Mary		artment of H			iena 007	33180
			Decedent's Name (First, Middle, Last)					2. Date of Death Month	h Day Year	3. Time of Death
	Physicia		Mirna Guadalu	pe Plac	ido Sa	avedra		Septembe		14
	/Medic Examin		4a. Facility Name (If not institution, give			4b. City, Town, or	Location of Death		4c. County of De	ath
	LAGIIIII		Holy Cross Hospit	:a1		Silver	Spring		Montgo	
	Funeral		5. Sociat Security Number 6. Sex	7. Age (In	yrs. last birthday)	If Under 1 Year Months Days	tf Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year) 9. B	irthplace (State or Foreign Country)
	Director		None	M 2137	O Yrs.		2 30	Sept. 25	, 2007 M	aryland
	pu *		Usual Residence of Decedent 10a. State 10b. County	10	c. City, Town or Lo	ocation				10d. Inside City Limits
	anyla sho	ъ								1 ☐ Yes 2 ☑ No
	the N	Director	Maryland Prince 10e. Street and Number	Georges	Bladensh	10f. Zip Code		1	0g. Citizen of What (Country?
	with					2071	n		United S	tates
	ns 23	eral	4214 54th Place	12. Was Decedent Ever	r in U.S. 13.		ispanic Origin? (Spe in, Mexican, Puerto	cify Yes or No-	14. Race - An	nerican Indian,
	Iter d	Fu	1 ☑ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 ☑ No	1			Hican, etc.)	Black, Wh	nite, etc.
ဗ္ဗ	urs a	by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1 X Yes 2 □ No	Specify: Me:	xican	Specify: Ot	her
Ŏ	within 72 hours after death with the Maryland ene. than "netural", or Items 23e or 28a-f show I.a Madical Exantiral must be inclifted a	ted	15. Decedent's Edu (Specify only highest grad		16a. Dece	dent's Usual Occup	ation during most of worki	ng	16b. Kind of Busines	s/Industry
2	thin 7	ple	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retired	during most of worki			
7	ed wi	Completed by Funeral	0			None	18. Mother's Name	/First Middle /	Non	.e
2	d oth	Be	17. Father's Name (First, Middle, Last)							
Maryland 21215-0036	ould Men Marke	ျှ	Edgar Placido	Gried)	10h Mais	a - Addraga (Stroot	Liliana		redra r, City or Town, State	Zin Code)
Nar	12 sh and r 7 le m	1	19a. Informant's Name/Relationship (7)				ce, Blade:			20710
a)	1 and 16altl 9m 2		Edgar Placido / E		20b. Place of Dispe	osition (Name of			20c. Location - City	
٥	ages nt of l		1 ☐ Burial 2X Cremation 3 ☐F	Removal from State		matory or other place		/2007	Dwantrand	, Maryland
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 le marked other than "netural; or titems 23e or 28a-f show any injury or other treumatic event, it is marked to the treumatic event, it is marging to the treumatic event, it is marging to the treumatic event.		 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licens 			2. Name and Addre	tory 9/30	mple Tri		, Maryland
Ba	perm Depa Impo any i		21.39				D 1			land 20852
			23a. Party Enter the disease, pricomp shock, or heart failure. List only o	lications that caused the	death. Do not en	ter the mode of dyir	ng, such as cardiac	or respiratory arr	est,	Approximate Interval Between
			Immediate-Cause (Finat							Onset and Death 12 weeks
	Pnysician /Medical		disease or-condition resulting in death)	a. Hypoplas Due to (or as a co		5				12 weeks
	Examiner			Extreme		itv				
		iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a co						
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Ó	death certificate be executed e attending physician and of for use as the burial-transit		resulting in death) Last	Due to (or as a co	onsequence of):					
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9	ing p	Mec	tF FEMALE:	OG If was autooms of a	2000004				22d Data of	dolivan
Вох	ath ce	Physician/Med	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of p	Fetal death 3	☐Ectopic pregnancy ☐ Other (specify)	у		23d. Date of Month	Day Year
0	O O	ysic	1 ☐ Yes 2 ☒ No 9 ☐ Unknown	4□Pregnant at tim 9□Unknown	ie oi death 5	Other (specify)				
σ.	requires that the de leen signed by the hould be detached		Part II. Other significent conditions co	ntributing to death but n	ot resulting in the	underlying cause giv	en in Part I.	23e. Did to	bacco use contribute	to the cause of death?
ds,	es un eq	d by						1 □ Y	′es 2⊠No 3⊟	Probably 4 Unknown
Ö	w requir been si should	Completed						24a. Was a	an 24b. Were	autopsy findings available
æ	e la has	E						autop: perfor	rmed? death	
ā	(0 52	e Co	25. Was case referred to medical				26. Place of Deat			63 2 110
of Vital Record		(C)	evaminer?	Hospital: 1X Inpatient	2 🗆 ER/Outpatie	ent 3 DOA Ott	205	Company of the Compan	lence 6 □Other (S	pecify)
of		n: To	27. Manner of Death	28a. Date of Injury (Month, Day Y	28b. Time	The same of the sa	ry at	28d. Describe h	now injury occurred	
ion	.≅ . ≨ 5	ate	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation		our, injury		Yes 2 □No			
Division	Il or Attendi after death. I Director: A d in by the fu	ific	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury building, etc. (- At home, farm, s	treet, factory, office		28f. Location (S City or Tow	Street and Number or vn, State)	Rural Route Number,
	tal or s afte el Dir	Certification;	//							
	e Hospital or , 124 hours after e Funerel Dire	Medical	29a. Certifier 1 ☐ Certifying Phy (Check only one) 2 ☐ Medical Exam	ysicien: To the best of r iner: On the basis of ex and manner states	amination and/or i	th occurred at the ti nvestigation, in my	me, date and place, opinion, death occur	and due to the d red at the time, d	cause(s) and manne date and place, and	as stated. due to the cause(s)
	To the Hos within 24 hor To the Fun completely	Me	29b. Signature and title of certifier			29c. Licen	se number	:	29d. Date signed (M	onth, Day, Year)
	⊢≯⊢ō		15 D. M.E	Och	0	D00	062206		9/25/20	07
			30. Name and address of person who	completed cause of deal	th (Item 23a) (Type	, Print)				
			Jessica D. McAdo	o, M.D.	1500 For		Road, Sil	ver Spri	ing, Maryl	and 20910
		ate	31. Date filed (Month, Day, Year)	32 Registrar's	Signature	_		_		
	Regist	rar	OCT 0 2 20	JI DESEUR	K. A.	28062.5		_		

		_	For State	State of Maryla	and / Depa	artment	of Health and of Death	d Mental Hyg	iene eg. N2 0 0 7	33181
			Registrar 1. Decedent's Name (First, Middle, Last,)			0, 5 00	2. Date of Deat	th	3. Time of Death
	Physici		Genesis Aileen	Placido	Saave	dra		Septembe	er 26, 200	7 12:40 ам
	/Medio Examin	_	4a. Facility Name (If not institution, give			4b. City, T	own, or Location of De		4c. County of Dea	
		Ÿ.	Holy Cross Hospi	tal		Sil	ver Spring	5	Montgom	
	Funeral		5. Social Security Number 6. Se	x 7. Age (In y	rs. last birthday)	If Under 1 Months	Days Hours M	in. (Month, Day,	Year) 9. Bir	thplace (State or Foreign
	Director		None	JM 2124F	O Yrs.		4 5	4 Sept. 25	5, 2007 M	aryland
	and W		Usual Residence of Decedent 10a. State 10b. County	10c.	City, Town or Lo	cation				10d. Inside City Limits
	daryll f sho	6	V1 - 1 D1	0	Dladon	- 1				1 ☐ Yes 2 ☑ No
	the t		Maryland Prince 10e. Street and Number	Georges	Bladen	10f. Zip (Code	1	0g. Citizen of What C	ountry?
	3a or		4214 54th Place			2	0710		United S	tates
	death ms 2	Funeral	11. Marital Status	12. Was Decedent Ever in Armed Forces?	n U.S. 13.	Was Decede	nt of Hispanic Origin? y Cuban, Mexican, Pu	(Specify Yes or No-	14. Race - Ame Black, Whi	
ဖွ	after or Ite	F	1 ☑ Never Married 2 ☐ Married	1 ☐ Yes 2 ☑ No If Yes, Give		1 🔀 Yes 2		, , ,	Specify:	0, 000.
Maryland 21215-0036	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or Items 23a or 28a-1 show aumatic event, the Medical Examinar must be notified at	d by	3 Widowed 4 Divorced	Year or Dates:			N	lexican	0	ther
5-	nati	lete	15. Decedent's Edu (Specify only highest grad	ication le completed)	(Give	dent's Usual kind of work DO NOT use	done during most of		16b. Kind of Business	rinduştry
12	withir ane. than	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	No		(all ed)		None	
d 2	filled Hygie other	ပိ	17. Father's Name (First, Middle, Last)		110.		18. Mother's	Name (First, Middle, I	Maiden Sumame)	
an	Id be ental ked c	To Be	Edgar Placido				Lilia	na Saave	dra	
аī	2 should and Men ts marke aumatic		19a. Informant's Name/Relationship (T)	rpe, Print)	19b. Maili	ng Address (Street and Number or	Rural Route Number	, City or Town, State,	Zip Code)
2	s 1 and 2 should be filed within 72 hours after death with the Marylar f Heath and Mental Hygiene. It heath and Mental Hygiene. Item 27 is marked other than "natural", or Items 23a or 28a-1 show other traumatic event, I'le Medical Examinational be notified at		Edgar Placido / F	ather	4214	54th P	lace, Blac			20710
Baltimore,	es 1 and 2 of Health item 27 t		20a. Method of Disposition 1 ☐ Burial 2 ☒ Cremation 3 ☐ I	,	 b. Place of Dispo cemetery, crei 	sition (Name matory or oth	e of ner place)	Date	20c. Location - City or	Town, State
<u>Ĕ</u>	nit. Pages 1 artment of H. ortant: If iter injury or oth		`4 □ Donation 5 □ Other (Specify)	F	t. Linco	ln Cr	ematory 9/	30/2007	Brentwood	Maryland
alt	permit. Pages Department of Important: If it any injury or c		21. Signature of Funeral Service Licens	888			Address of Facility	Simple Tr		
_	89729		W SU						ille, Mary	Land Approximate
	Physician		23a. Part1. Inter the disease, or comp shock, or hear failure. List only of Immediate Caus. (Final disease or population	ne cause on each line. Hypoplas			or dying, such as care	nac or respiratory arr	est,	Interval Between Onset and Death 12 weeks
7	/Medical		resulting in death)	Due to (or as a con		55				
- 1	Examiner		Sequentially list conditions	b. Extreme		rity				
0	D #	Examiner	Sequentially list conditions, if any, leading to immediate cause. Obsease or injury that initiated events	Due to (or as a con	sequence of):					
5	tte be executed tysicien and ne burial-transit	am	that initiated events resulting in death) Last	c Due to (or as a con	sequence of):					
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687	physicate			d						
×	leath certificat attending phy ifor use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pre					23d. Date of de	livery
Вох	 requires that the death cer been signed by the attendir should be detached for use 	ciar	in the past 12 months? 1 □ Yes 2 ☒ No	1 Live birth 2 ☐ F 4 ☐ Pregnant at time		⊒Ectopic pre ⊒ Other <i>(spe</i>			Month	Day Year
P.O.	it the d by the tached	hys	9 Unknown	9□ Unknown						
	uires that signed b	by P	Part II. Other significant conditions co	ntributing to death but not	resulting in the u	inderlying ca	use given in Part I.		bacco use contribute t	
ğ	equire en sig							- 1 <u>0</u> Y	es 2.⊠No 3.∏P	robably 4 Unknown
Vital Records,	ne law requ has been ge 2 shoult	Completed						24a. Was a autops	an 24b. Were a	utopsy findings available completion of cause of
æ	The ate has page	E O						perform 1 ☐ Yes	med? death? 2≦No 1⊟Ye	s 2 No
/ita	iician: Th certificate rector, pag	Be (25. Was case referred to medical examiner?					Death (Check only or		
	Physic this cr	၉	T Tes 2 ZAINO		2 ER/Outpatie	teritor distance in the			ence 6 Other (Spe	ecify)
n o	Jing P	i,	27. Manner of Death 1 ⊠Natural 5 □ Pending	28a. Date of Injury (Month, Day Yea	r) 28b. Time of Injury	M 28	c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe n	ow injury occurred	
Sic	death death stor:	cat	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury - /	At home farm st			28f. Location (S	treet and Number or F	lural Route Number,
Division of	l or A after Direction by	Certification;	4 ☐ Homicide determined	building, etc. (Sp	ecity)	ioot, idotory,	3	City or Tow	n, State)	
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	edicai C	(Check only 2 Medical Exam	vsician: To the best of my iner: On the basis of exar	knowledge, deal	th occurred a	t the time, date and p in my opinion, death o	ace, and due to the cocurred at the time, of	ause(s) and manner a late and place, and du	s stated. e to the cause(s)
	the the the the the the mplet	Med	one) 29b. Signature and title of certifier	and manner stated.		29c.	License number	2	29d. Date signed (Mor	th, Day, Year)
	To To		1920 m	: On 6	(0)		D0062206		9/26/20	
			30. Name and address of person who of	ompleted cause of dooth	(Item 23a) /Turco	Print)	20002200			-
			Jessica D. McAdo				n Road S	ilver Spri	ng, Maryla	nd 20910
	Sta	ate	31. Date filed (Month. Dav. Year)	32. Agistrar's S	ignature			TANT NATT		
	Regist	rar	OCT 0 2 2	JUI Blown	H. A	MARIN	10			

DHMH 17 Rev 1/2001

		1 - For State Registrar	State	of Marylan	•	artmen <i>tificat</i>			Mental		ene 0	7	33182
Physic	cian	1. Decedent's Name (First, Midda Cynthia Odell							Mont		Day 20	Year	3. Time of Death 5:40 A ^M
/Med Exam		4a. Facility Name (If not institution Kline Hospice	n, give street and no	ımber)				Location of De		Del	4c. Count	y of Death ederi	
Funera Directo		5. Social Security Number	6. Sex 1 ☐ M 2/10/1F	7. Age (In yrs. 7			1 Year	If Under 24 H	n. 8. Date (Mon Marc	of Birth	Year) , 1935	9 Birthi	place (State or Foreign
		Usual Residence of Decedent 10a. State 10b. County Maryland Fred	erick	10c. City	y, Town or Lo								10d. Inside City Limits 1 ☐ Yes 2 ☑ No
or 28e	Director	10e. Street and Number				10f. Zip	Code			10	g. Citizen of	What Cou	intry?
should be filed within 72 hours after deeth with the Maryland should be filed within 72 hours after deeth with the Maryland and Mental Hygiene. n marked other than "natural", or items 23a or 28e-1 show unastic event, the Madical Exeminar must be notified at	by Funeral	8410 Stonehouse 11. Marital Status 1 Never Married 25 Mar 3 Widowed 4 Divorced	12. Was Der Armed F ried 1Yes	2⊠No iive	,	Was Dece	cify Cubai	spanic Origin? n, Mexican, Pur Specify:	(Specify Yes erto Rican, et	or No-	BI		ican Indian, , etc.
within 72 ho lene. rthan "natur the Madical	Completed	15. Deceder (Specify only higher Elementary/Secondary (0-12)	nt's Education st grade completed College	(1-4or 5+)	16a. Deced (Give life. A	kind of wo DO NOT u	rk done a se retired,	uring most of w	vorking	1	6b. Kind of	Business/Ir	ndustry
a y a land A LA. 2 should be filed withir and Mental Hygiene. ie marked other than aumatic event, the Mental	To Be Co	17. Father's Name (First, Middle, William Leon G			1			18. Mother's N	lame (First, A				
d 2 sho	ľ	19a. Informant's Name/Relation		1	1			nd Numberor se Dr. 1					p Code)
permit. Pages 1 end 2 should be Department of Heelih and Menta important: If Item 27 is marked eny injury or other traumatic a		Eugene W. Smit 20a. Method of Disposition 1 Straight 2 Cremation 4 Donation 5 Other 6	3 Removal from	20b. F	Place of Disponentery, cres Rest	sition (Na natory or c haver	me of other place	e) Oct	Date 3,	2	20c. Location	- City or T	own, State
permit. P Departme importan eny injur		21. Signatur Fineral Service	2] Me.	morial Re	Name a	nd Addres	s of Facility Funeral tin Mtn	Servi	ces,	Skko	t Cod	y P.A.
Physiciar	n	23a. Part1. Enter the disease shock, or heart failure Lis Immediate Cause (Findisease or condition		caused the deat each line. ardial	h. Do not ent	er the mo							Approximate Interval Between Onset and Death hours
/Medica Examine	r	resulting in death) Sequentially list conditions, if any, leading to immediate	_{b.} Ovar	ian Canc	er								months
The law requires that the death certificate be executed ste has been signed by the attending physicien and page 2 should be deteched for use as the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate course. The Index of Cause (Disease or injury that initiated events resulting in death) Last	c. Due to	o (or as a conseq	juence of):								
thet the death certific ed by the attending p	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ⊠No 9 □ Unknown	1 Live	utcome of pregna birth 2 Feta gnant at time of c nown	ul death 3	⊒Ectopic p □ Other (s						Date of deli-	very Day Year
w requires that is been signed by should be dete	<u>۾</u>	Part II. Other significant condit	_	death but not res	sulting in the u	indertying	cause give	en in Part I.	23e		eaccoluse co		the cause of death?
OI VILAI INECO Physician: The law re- rithis certificete hes bee aral director, page 2 sho	Completed								-	. Was ar autops perform Yes 2	y I	prior to c death?	topsy findings available completion of cause of
Physician: rthis certificant ral director.	Be (25. Was case referred to medic examiner?	Hospital:				Oth	26. Place of D					70
nding Physith.: After this efuneral dir	Ö	1 ☐ Yes 2 ☑ No 27. Manner of Death 1 ☑ Natural 5 ☐ Pend 2 ☐ Accident inves	28a. Dat	Inpatient 2 C e of Injury onth, Day Year)	28b. Time o Injury		28c. Injun Worl	4			ince 6 <u>S</u> C w in∤ury occ		Hospice
To the Hospital or Attending Ph within 24 hours after death. To the Funaral Director: After th completely filled in by the funeral	Certificati	3 ☐ Suicide 6 ☐ Could	I not be zee. Pla buil	ce of Injury · At h Iding, etc. (Speci	ome, farm, st	reet, facto	y, office			ation (St.		nber or Ru	ral Route Number,
he Hospit n 24 hours ne Funara	edical	29a. Certifier 1XX Certify (Check only one)	ing Physician: To to I Examiner: On the and ma	he best of my kno basis of examina anner stated.	owledge, deat ation and/or in	th occurred	at the tin	ne, date and pla pinion, death o	ace, and due ccurred at the	to the ca	ause(s) and ate and plac	nanner as a, and due	stated. to the cause(s)
To the To the comp	Ž	29b. Signature and title of certifi	er	(IN)			c. Licens						n, Day, Year)
8		30. Name and address of perso	who completed ca			Print)) 441				ctober		2007
		A. Zakaria Heg	azi, M.D.					Dr. Fre	derick	, MI	2170	2	
Regis	State strar	31. Date filed (Month, Day, Year OCT 0	3 2007	Algistrar's Sign	JE A	podi	1						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** Simpson Saxon Voss 3:30 P^M 2007 October 2 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 916 Motter Avenue Frederick Frederick If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months 1 M 2 TxF 61 212-50-9008 Director June 15, 1946 North Carolina Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 X Yes 2 □ No Director Frederick Maryland Frederick 10e Street and Number 10g, Citizen of What Country? 10f. Zip Code 21701 USA 916 Motter Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give X Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify. ģ Specify: White 3 Widowed 4 Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Owner/ Operator Retail Liquors 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) C. Gerald. Yonetz, Sr. Iris Voss ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 916 Motter Avenue, Frederick, MD 21701 George L. Simpson/Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ACremation 3 ☐ Removal from State 10/3/2007 4 ☐ Donation 5 ☐ Other (Specify) Frederick, MD 21702 Stauffer Crematory 21. Signature of Funeral Service Lice 22. Name and Address of Facility Stauffer Funeral Home, PA 1621 Opossumtown Pike, Frederick, MD 21702 23a. Part 1 oner the disease, o complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sheek, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** eytrasive /Medical Due to (or as a consequence of) **Examiner** percholos Sequentially list conditions Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed 44 hours after death. Funeral Director: After this certificate has been signed by the attending physician and stely filled in by the funeral director, page 2 should be detached for use as the burital-transit Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9☐Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Tyes 2€No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy death? 1 □ Yes 2□No 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 100 Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 ☐ Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours at To the Funeral D

State Registrar

completely

Medical

29a. Certifier

(Check only one)

29b. Signature and title of certifier

Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 @ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) $^{\text{Month}}/27/2007$ 5:30am Alta Loraine Sawyer 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Anne Arundel Annapolis Spa Creek Center If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 8/19/1912 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Days Hours Min 1 □ M 2 √ F 95 Nebraska 215-20-4049 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐Yes XXNo Davidsonville Maryland Anne Arundel 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 571 Jamestown Ct. 21035 USA 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes AN No If Yes, Give Year or Dates: 1 Never Married 2 Married White 1 ☐ Yes 2 No 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Office Manager Contractor 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Hervey Hinote Bertha George 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Craig Sawyer Son 5493 Solomons Island Rd. Lothian, MD 20711 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Davidsonville U.M. 10/02/2007 Davidsonville, MD 22. Name and Address of Facility Hardesty Funeral Home, P.A. 21. Signature of Funeral Salvice Licenses Annapolis, MD 21401 12 Ridgely Ave. Approximate Interval Between Onset and Death 23 Pa .. Enter the shock, or hea sease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, allure. List only one cause on each line. I mmed te Caus (r inal disease or condition resulting in deat Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter United Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9□Unknown 9 I Inknown 23e. Did tobacco use contribute to the cause of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 Probably 4 Nknown

Physician /Medical Examiner

The law requires that the death certificate be executed

and

physician

.O. Box 68760,

Division or Vital Records, P.

or Attending Physician:

Hospital within 24 hours a To the Funeral I

this

After

Physician

/Medical

Examiner

Director

Funeral

þ

Completed

Be

Funeral

Director

the Maryland

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a f show any Injury or other traumatic event, the Medical Examiner must be notified at once.

3altimore, Maryland 21215-0036

Examiner burial-transi Physician/Medical the as been signed by should be detac ģ Completed Be Certification: To ours after death.
neral Director: Af

24a. Was an autopsy perform 2 No

28d. Describe how injury occurred

Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 Yes No No 27. Mannet of Death Natural 5 Pending investigation

Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28h Time of

and manner stated

Other: Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

29b. Signature and title of

Medical

2 ☐ Accident

3 ☐ Suicide

4 ☐ Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) 29c. License number

26. Plage of Death (Check only one)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Annapolis, MD 21401 1000

5 CT. State Registrar

hopra 8 2007

6 □Could not be

rtifie

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Month Day Dorothy E. Smith 2007 September /Medical Pacility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner alisbure Medical Lenter Nicamica egIONAL 8. Date of Birth (Month, Day, Year) if Under 1 Year | If Under 6, Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days 1 ☐ M 2 🕱 F 221-09-6508 **Director** 94 Delaware Sept. 11, 1913 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a. State 10d. Inside City Limits 28a-f show be notified at Director 1 X Yes 2 No MD Wicomico Delmar 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 0 with 301 E. Elizabeth Street 21875 U.S.A. Funeral Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married "natural", or 1 ☐ Yes 2 XNo white ģ Specify: 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) is marked other than "natu aumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Baltimore, Maryland 2121\$ Elementary/Secondary (0-12) College (1-4or 5+) Health and Mental Hygiene. 10 Seamstress Garment Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ira L. Wilson Delia E. Parsons 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 i other tra Susan S. Parks 21804 (Daughter) 4815 Meadowlark Dr. Salisbury, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages
Department of
Important: If it
any Injury or o 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Stephens Cemetery Oct. 1, 2007 Delmar, Delaware 22. Name and Address of Facility
Short Funeral Home
13 E. Grove Street 21. Signature of Funeral Service Licensee Delmar, DE 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of) Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) P.0. as been signed by the a should be detached 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Be Completed by 4 Unknown 1 Yes 2 No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe page 25. Was case referred to medical 26. Place of Death (Check only one) Certification: To 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Mann of Death 28a. Date of injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation (Month, Day Year) atural To the most after death.

Within 24 hours after death.

To the Funeral Director: Aft 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and tipe of certific 29c. License number 29d. Date signed (Month, Day, Year) MO

DHMH 17 Rev 1/2001

221-09-6508

State Registrar power

100 32 Registrar's Signature

30. Name and address of person who completed cause of death (item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		_	For State Registrar	Otate of Waryiar		rtificate of			Reg. No.	2007	33186
	Physicia		1. Decedent's Name (First, Middle, Lat DOUGLAS JAMES					2. Date of De Month SEPT	ath Day	2007	3. Time of Death 5:30 A M
	/Medic Examin		4a. Facility Name (If not institution, give	e street and number)		4b. City, Town, o	r Location of Death			County of Deat	
			SHADY GROVE ADV			ROCK'	VILLE If Under 24 Hrs.	8. Date of Bir		ONTGOM	
	Funeral Director		5. Social Security Number 6. S 228-13-2817 1 Usual Residence of Decedent	7. Age (In yrs. 45	Yrs.	Months Days	Hours Min.	OCT 2	y, Year) 0 19	61 9. Birti	hplace (State or Foreign untry) MD
	yland now at		10a. State 10b. County		ty, Town or Lo						10d. Inside City Limits
	e Mar 3a-f sh tified	Director	MD MONTGO	OMERY	GERMA	NTOWN					1 □ Yes 2 ☑No
	th with th 23a or 28 ust be no		13100 ROSEBAY	DRIVE		10f. Zip Code 20874			U	izen of What Co ISA	
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f show he Medical Examiner must be notitled at	d by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 ☑ Divorced	12. Was Decedent Ever in L Armed Forces?/ 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 ☐ No	Specify:	pecify Yes or No o Rican, etc.)		14. Race - Amer Black, White Specify: WH	e, etc. IITE
15-0	י 72 ה "natu edical	letec	15. Decedent's Ed (Specify only highest gra	ducation ade completed)	16a. Dece	dent's Usual Occup kind of work done DO NOT use retired	ation during most of wor d)	king	16b. Ki 	ind of Business/	Industry
212	d within 72 ho giene. r than "natu the Medical	Completed	Elementary/Secondary (0-12)	College (1-4or 5+) 5 +		FESSOR	-/		EDU	CATION	1
pu	Hyg Hyg	BeC	17. Father's Name (First, Middle, Last				18. Mother's Nan	· ·		Surname)	
yla	ould be I Mental narked o	2	JAMES YOUNG SI		401 14 17	ng Address (Street		RAE CO			Z'- Conto
Maryland	nd 2 should lith and Men 27 is marke r traumatic		19a. Informant's Name/Relationship (RONDA COOK / N	**		8 CLOVE					•
Baltimore,	ss 1 ar		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐	20b.	Place of Dispo cemetery, cre	osition (Name of matory or other pla	ce)	Date	20c. Lc	ocation - City or	Town, State
Itim	그 돈 뭐 글		4 ☐ Donation 5 ☐ Other (Special Signature of Funeral Serv. e Liger			R CREMA		29/07	FRE	DERICK	, MD
Ba	permi Depar Impor any ir			7		HILTON I	FUNERAL	HOME ARNESV	LLLE	, MD	20838
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	ng, such as cardia	or respiratory a	ırrest,		Approximate Interval Between Onset and Death			
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)								
	Examiner										
	D #	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events								
	ecute and I-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a consec		LUKE					
68760,	rtificate be executed og physician and as the burial-transit	Aedical E		ESOPHAGEA		RICEAL B	LEEDING				
k 68		Med	IF FEMALE:								e
P.O. Box	The law requires that the deeth cert ate has been signed by the attendine bage 2 should be detached for use	Physician/	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome pf pregr 1 ☐ Live birth 2 ☐ Fet 4 ☐ Pregnant at time of 9 ☐ Unknown	al death 3	□Ectopic pregnanc □ Other <i>(specify)</i> _	у			23d. Date of del Month	ivery Day Year
ls, p	res that signed b	þ	Part II. Other significant conditions CHRONIC LIVE	*	sulting in the u	underlying cause giv	en in Part I.				the cause of death?
Sor	w requires been signi should be	eted	CHRONIC ALCO					24a. Was		_	utopsy findings available
or Vital Records,		Completed						auto		prior to	completion of cause of
Vita	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:		Ott	nor:	ath (Check only			
o	Phys r this eral dir	1. To	1 ☐ Yes 2 No 27. Manner of Death	28a. Date of Injury	28b. Time o	III 3 DOA	4 Li Nursing r	lome 5 ☐ Res 28d. Describe			cify)
ion	Attending F r death. ector: After by the funer	ation	1 Natural 5 □ Pending 2 □ Accident investigatio	(Month, Day Year) n	Injury		rk? Yes 2∐No				
Division	ospital or Attenchours after death hours after death uneral Director: ly filled in by the it	Certification:	3 Suicide 6 Could not b 4 Homicide determined		nome, farm, st	treet, factory, office		28f. Location City or To			ural Route Number,
_	T 4 11 0	Medical Co		hysician: To the best of my kr miner: On the basis of examin and manner stated.							
	To the I within 24 To the I complet	Me	29b. Signature and title of certifier	7		29c. Licens	se number			te signed (Mont	
			an			5000	J-10		 	PT. 27	, 2007
	0/		30. Name and address of person who ARDEKANI SANAC				ER DR	ROCKUT	T,T.©	MD 2	0850
		ate	31. Date filed (Month, Day, Year) OCT 0 2 2	32. Fegistrar's Sign	nature	and Carrie	IN DIV.	MOCKVI	<u>. TTE</u>	, MU Z	0000
	Regist	el.	001 0 2	The same of							

State of Maryland / Department of Health and Mental Hygien 33187 Certificate of Death 3. Time of Death 2. Date of Death Decedent's Name (First, Middle, Last) Day Month **Physician** 6:01 October Blanche L. Sterling /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Washington Ravenwood Lutheran Village Hagerstown If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month Day) 8/17/1914 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number Year) WEST VIRGINIA **Funeral** 1 M 2 F Months 93 234-01-7087 Director Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours after death with the Maryland 10c. City, Town or Location 10b. County 28e-f show ? I e marked other than "naturel", or items 23e or 28e-f shov treumetic event, the Micical Exprinter austice nutified at 1 ☐ Yes 2 ☑ No **HAGERSTOWN Funeral Director** WASHINGTON MD 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number 21740 USA 1109 LUTHER DRIVE 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. 11 Marital Status 1 Never Married 2 Married WHITE 1 ☐ Yes 2 ☑ No Baltimore, Maryland 21215-0036 Specify: ģ 3 √Widowed 4 □ Divorced 16b. Kind of Business/Industry Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) NATIONAL FRUIT permit. Pages 1 and 2 should be filed withir Department of Health and Mental Hygiene. Importent: If item 27 is marked other than eny injury or other treumatic access. Elementary/Secondary (0-12) College (1-4or 5+) PICKER/SORTER (APPLE PACKAGING) 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) BESSIE V. WHITTINGTON SAMUEL CLEMMONS 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) MD 21740 738 SUMMIT AVE., HAGERSTOWN, HARRY STERLING, III/SON 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition **OCTOBER** 1 Burial 2 □ Cremation 3 □ Removal from State MARTINSBURG, WV ROSEDALE CEMETERY 11,2007 4 ☐ Donation 5 ☐ Other (Specify) BROWN FUNERAL HOME, P.O. BOX 821, 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 327 W. KING ST., MARTINSBURG, WV 25402 23a. Part1. Enter the disease, or complications to t caused the death. Du not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause if n each line. Approximate Interval Betw Immediate Cause (Final disease or condition resulting in death) Privsician /Medical ue to (o) as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury be executed burial-transit attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of Division of Vital Records, P.O. Box 68760, Physician/Medical The law requires that the death certificate IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 2 Tetal death 3 Ectopic pregnancy Year Month in the past 12 months 5 Other (specify) 1 ☐ Yes 2 ☑ 110 the detached 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 3 ☐ Probably 4 ☐ Unknown ed bluods 1 ☐ Yes 2 ☐ No has been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? page 2 2 110 1 Yes To the Hospitel or Attending Physicien: 26. Place of Death Check on one director, Be 25. Was case referred to medical examiner? Other: 4 Jursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 1 Yes 2 ₩ 1 Inpatient ဥ 28c. Injury at Work? 28d. Describe how injury occurred Director: After that in by the funeral 28a. Date of Injury (Month, Day Year) 27. Manner of De Certification; Injury 1 Amatural 5 Pendina 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Thomicide within 24 hours a To the Funerel I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier cal 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed 31. Date filled (Month, Day, Year)
OCT 1 5 2007 State Registrar

	ل	State of Maryland - For State Registrar	Certificate of		Reg. N	20	07 33 {					
hysicia Examir	11//	1. Decedent's Name (First, Middle,Last) FRANK L. SMITH,	Jr.		Month Day September 2	y Year 1, 2007	0805 hrs					
		4a. Facility Name (if not institution, give street and number) Northwest Hospital Center	4	b. City, Town, or Location of Deatl Randallstown	n -	4c. County of Deat Baltimore Co						
ineral rector		5. Social Security Number 6. Sex 7. Ag 227-39-2979 1 M	e (In yrs. last birthday) 35 Yrs.	If Under 1 Year If Under 24Hr Months Days Hours Mir	DEC.23	Forci						
any.		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Location	on	<u> </u>		10d. Inside City Limits					
*	٦	MD Baltimore	Balti	more			1 Yes 2 X No					
23a or 28a-f sho notified at once.	Director	10e. Street and Number 106 South Highland 2	Avenue	10f. Zip Code 21224	10g. C	U.S.A	-					
or items must be	- L		? If Ye	s Decedent of Hispanic Origin? (Ses, specify Cuban, Mexican, Puerto		White, etc.	rican Indian, Black,					
xaminer	<u>۾</u>	Widowed 4 Divorced If Yes, Give Year or Dates: Decedent's Education (Specify only highest grade continuous)	mpleted) 16a. Decedent	Yes 2X No specify: 's Usual Occupation (Give kind of options of working life. DO NOT use re		Specify: BLack 16b. Kind of Business/Industry						
fental Hygiene. narked other than "natural", event, the Medical Examiner	Completed	Elementary/Secondary (0-12) College (1-4 or 5 +	5+)	chology Assoc		Medic	cal					
al Hygie ed othe it, the A	Be Col	17. Father's Name (First, Middle, Last) Frank Smith, Sr			e (First, Middle, Maid	,						
	ToB	19a. Informant's Name/Relationship (Type, Print) Ruth C. Via (Mother)		Address (Street and Number or Angus Rd, NW		, City or Town, Stat	e, Zip Code)					
Department of Health and I Important: If item 27 is r injury or other traumatic	ĺ	20a. Method of Disposition 1 X Burial 2 Cremation 3 X Removal from State 4 Opnation 5 Other Specify: 20b. Place of Disposition (Name of cemetery, crematory or other place) Tyree-Muse Family Cem 9/28/07 Frank										
Departm Importa injury o	22. Name and Address of Facility SNOWDEN FUNEPAL 246 N. Washington St, Rockvil 23a. Part I. Enter the disease, or complications that caused the death. To not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Saddle Pulmonary Thromboembolism											
sician edical												
miner		or condition resulting in death) Due to (or as a cons	sequence of):			Between Onset and Death						
	niner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause		ne Eximensia - m								
and - transit	Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a cons	sequence of):									
ysician ar burial - t	ledical	UNPENDED AMENDED										
e attending phys for use as the b	sician/N											
ed by th	by Phy	Part II. Other significant conditions contributing to dea	th but not resulting in the u	nderlying cause given in Part I.			o the cause of death?					
ite has been sign ige 2 should be	Completed				24a. Was an autopsy performer	prior to d? death?						
certificate ector, page	Be	25. Was case referred to medical examiner?		26.Place of Death (Check								
fter this oneral dire	욘	1 Yes 2 No Inpati 27. Manner of Death 28a. Date of In	ent 2 ER/Outpatient		ing Home 5 Res	injury occurred	er:					
r death. rcctor: A by the fu	ication	Natural 5 Pending Accident Investigation		1 Yes 2 No	28f. Location (Stre	et and Number or F	Rural Route Number, City					
hours afte	Certification;	Suicide Could not be determined (Specify)			or Town, State	•)						
within 24 h To the Full completely	Medical	(Check only one) 2 Medical Examiner: On the basis of examiner stated	amination and/or investigat	red at the time, date and place, ar ion, in my opinion, death occurred	nd due to the cause(s) at the time, date and) and manner as sta place, and due to	ated. the cause(s)					
T _O	Me	29b. Signature and title of certifier	er 29d. Date signed (Month, Day, Year)									
J		30. Name and address of person who completed cause of death (Item 23a)										
		30. Name and address of person who completed cause of	death (Item 23a)									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 12, **Physician** Patricia September Shipway 2007 8:27 A M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 13304 Bealls Mill Road Cumberland Allegany 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 8. Date of Birth (Month, Day, Year) 05/31/1936 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days Hours 220-30-8794 Georgia Director Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits r 28a-f sh notified 1 □Yes 2 No MD Directo Allegany Cumberland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? r items 23a or 2 niner must be n 13304 Bealls Mill Road 21502 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married "naturai", or i edical Examin Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No þ Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) ã Nursing Assistant Hospital 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be nent of Health and Mental 27 is marked of traumatic ev Mobley (NMN) Wright Audrey Isabelle ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: if item 27 is any injury or other tra William D. Shipway, Sr./husband 13304 Bealls Mill Road, Cumberland, MD 21502 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State MD Vet. Cem @ Rocky Gap 09/14/2007 4 ☐ Donation 5 ☐ Other (Specify) Flintstone, MD 21. Signature of Funeral Service License 22. Name and Address of Facility Adams Family Funeral Home, P.A. 404 Decatur Street, Cumberland, MD Ta 23a. Part1. Enter the disease, or complications that caushock, or heart failure. List only one cause on ed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, th line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ANCREATIC CARCINOMA SIX MONTHS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner The law requires that the death certificate be executed physician and the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical as IF FEMALE: 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 🗷 No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9☐ Unknown 9 Unknown signed to d be det 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed has been a je 2 should 24b. Were autopsy findings available prior to completion of cause of autopsy performed? 2 No 2XNo 1☐ Yes the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 2 No 1 ☐ Yes ٩ 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide م 24 hou. the Funeral Dir 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. within 2. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D33417 September 12, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) James R. Moen, M.D., 1068 National Highway, LaVale, Maryland 21502 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 1 3 2007 Registrar leve & food DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TIEM/201 per PHYS 872 10/15/07 US
State of Maryland / Department of Health and Mental Hygiene 2 0 0 7 Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day **Physician** October 2, 2007 5:30 a. [™] Rose Squares /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Prince Frederick Calvert Calvert Memorial Hospital 8. Date of Birth (Month, Day, Year)
Aug. 3, 19 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex If Under 24 Hrs. Hours Min. **Funeral** Months 1 □ M 2 💢 F Yrs. 90 1917 Pennsylvania Director 165-14-7818 Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show r than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 1 ☐ Yes 2 No Director MD Calvert Owings the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8000 Bourne Road 20736 U.S.A. Pages 1 and 2 should be filed within 72 hours after death vent of Health and Mental Hygiene.

Int. If Item 27 Is marked other than "natural", or Items 23s Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married "natural", or 1 ☐ Yes 2 No Specify: Specify: ģ 3 Widowed 4 ☐ Divorced Year or Dates: white Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 6 homemaker own home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဥ Casiello Adelphia DiMartini Pietro 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If Item 27 is any Injury or other tra 8000 Bourne Rd., Owings, MD 20736 Richard A. Squares son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 10-3-2007 Alexandria, VA 22. Name and Address of Facility 2 Signature of Funeral Service Licenses Rausch Funeral Home, P.A. 8325 Mt. Harmony Lane, Owings, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on ach line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner DUSTANSION Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed as the burial-trar and Due to (or as a consequence of): attending physician Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy in the past 12 months? Month Day Year 4 □ Pregnant at time of death 5 Other (specify) Yes 2 No the 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1□ Yes 2□ No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner?
1 \(\text{Yes} \) 2 \(\text{No} \) Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: after death.
I Director: After this of in by the funeral dire 1 Inpatient 2 2 ER/Outpatient 3 DOA 27. Manner of Death 28a Date of Injury 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) 1 Natural 5 ☐ Pending investigation 2 Accident 1 Yes 2 No 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 | Homicide To the Hospital o within 24 hours aff To the Funeral Di completely filled in 🚧 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar

3

29b. Signature and title of certifier

Name and address of person who completed cause of death (Item 23a) (Type, Print)
MONOJ MATHUR 110 HUSPITAL ROLS

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

110 Huspital Rd Ste 305

32. Registrar's Signature

29c. License number

29d. Date signed (Month, Day, Year)

Oct. 3,2007

Prince Frederic Limb zours

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav 09:27 AM Walter Burton Terry 10 2 2007 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Baltimore Good Samaritan Hospital Baltimore | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year June 9, 15) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 XM 2 ☐ F 223-46-7004 70 Virginia Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2 No New Freedom PA York 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 17349 U.S.A. 448 Stone Arch Road 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Machine Operator Telephone 9 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Susie Elizabeth Sessor Walter Hughes Terry 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 448 Stone Arch Rd., New Freedom, PA 17349 Cecilia D. Terry / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place)
New Freedom
Cemetery Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 Removal from State 4 Donation 5 Other (Specify) 2007 New Freedom, PA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility J.J. Hartenstein Mortuary, 24 Second St., New Freedom, PA 17349 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sup 5 5 Due to (or as a consequence of): 24 hours diskitis Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) 23c. If yes, outcome pf pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) 1 Yes 2 No 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? End-stage renal disease, coronary artery disease, 2 No 3 Probably 4 Unknown 1 🗌 Yes Diabetes, Atrial fibrillation, Prostate Concer 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an autopsy 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation

Physician /Medical **Examiner**

Physician

/Medical

Examiner

Director

Funeral

Completed

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at

Baltimore, Maryland 21215-0036

The law requires that the death certificate be executed and burial-trar attending physician for use as the buria

Physician/Medical Completed Be

Certification: To Medical

2 Accident

3 Suicide

29a, Certifier

4 Homicide

State Registrar

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director,

Division or Vital Records, P.O. Box 68760

(Check only one) 29b. Signature and title of certifier M.D.

6 ☐ Could not be

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

29c. License number Res- 000

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year) 10/12/2007

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

AMIR KAZORY, 5601 Loch Raven Blvd, Baltimore, no 21239

31. Date filed (Month, Day, Year) OCT 1 6 2007 32. Registrar's Signature

			1 - For State Registrar		State of Ma	aryland / [rtment of F tificate of		ind Mental	Hygie Reg.	2007	33192		
77	Physici		1. Decedent's Name Robert W		aliaferro					Mont	of Death	Day Year 2007	3. Time of Death		
	/Medic Examin		4a. Facility Name (If	not institution, give	street and number)			4b. City, Town, o	r Location of		20,	4c. County of Death			
			11 Windb	rooke Ci	rcle			Gaithers				Montgomer			
7	Funeral Director		5. Social Security Nu 218-56-5	207	7. Ag	e (In yrs. last bir 56	rthday) Yrs.	If Under 1 Year Months Days	If Under 2 Hours	Min. (Mon	of Birth th, Day, Ye	9. Birth Con 1950 of (pplace (State or Foreign intry) District Columbia		
	and w		Usual Residence of 10a. State	Decedent 10b. County		10c. City, Tow	n or Lo	cation					10d. Inside City Limits		
	Maryl	tor	Maryland	Montgome	rv	Gaithe							1 V Yes 2 □ No		
	r 28a	Directo	10e. Street and Num			JULIA		10f. Zip Code			10g.	Citizen of What Cou	untry?		
	23a c		11 Windb	rooke Ci	rcle			20879			Ur	nited Stat	es		
36	ges 1 and 2 should be lifed within 72 hours after death with the Maryland it of Heelin and Mental Hygiene. I the fire 21 is marked other then "natural", or items 23 a or 28a-f show or other treumatic event, the Madical Examinar must be notified at	by Funeral	11. Marital Status 1 Never Marrie 3 Widowed		12. Was Decedent Armed Forces? 1 XYes 2 ☐ N If Yes, Give	√ 1968 –		Vas Decedent of H Yes, specify Cuba ☐ Yes 2 No	lispanic Orig an, Mexican, Specify:	in? (Specify Yes Puerto Rican, et	or No- c.)	14. Race - Amer Black, White Specify: Wh	, etc.		
Maryland 21215-0036	n 72 hour "natural edical E	Completed b	(Ѕресіі	15. Decedent's Ed by only highest grad	de completed)		Deced (Give	ent's Usual Occup kind of work done OO NOT use retired	nation during most	of working	16b	b. Kind of Business/I	ndustry		
212	giene.	Somp	Elementary/Secon	dary (0-12)	College (1-4or 5		old:				U.	.S. Army			
nd	be file ital Hy od oth event	Be	17. Father's Name (/							r's Name (First, M					
<u> </u>	should nd Men marke umatic	오			Caliaferro		N.A10			Stella T					
Ma Ma	and 2 sl belth an n 27 is r	1	19a. Informant's Na Anna Ste	lla Troia	ano Taliaf crett / Mo	erro						ity or Town, State, Zi Lle, MD 20			
5	Pages 1 and nent of He Int: if Item Int or other			osition	Removal from State	20b. Place of cometer Life I	ry, crem ∟ega	sition (Name of eatory or other place CY ation	ce)	Date 10/02/20		. Location - City or I			
Balt	permit. Page Department of Important: if eny injury or once.		21. Signature of Fun	eral Service Licen:		0956	22 T1	Name and Addre	Mortu	ary Serv	ice, lver	P.A. Spring, M	۵D 20910		
			23a. Part1. Enter the shock, or heart	e disease, or comp failure. List only o	lications that caused one cause on each lir	the death. Do							Approximate Interval Between		
	hysician		disease or condition	mmediate Cause (Final isease or condition sauting in death) ASCVO											
	/Medical Examiner		Due to (or as a consequence of):												
	* E	Jer	Sequentially list con if any, leading to imr	ditions, nediate	b. Due to (or as	a consequence	of):								
5	nd nd transit	Examin	Cause (Disease or in that initiated events		C										
58760,	ricate be executed physicien and is the burial-transit	al Ex	resulting in death) La	ast	Due to (or as	a consequence	of):								
	E 73 2 1	edical			d							. 1			
O. Box	ine law requires that the death centil te has been signed by the ettending lage 2 should be detached for use as	Physician/M	IF FEMALE: 23b. Was decedent in the past 12 n 1 Yes 2 9 Unknown	nonths?	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal death		Ectopic pregnancy Other (specify)	'			23d. Date of deliving Month	very Day Year		
ດ. ຕຸ	es that the de igned by the c be detached i	by Ph	Part II. Other signific	cant conditions co	entributing to death bu	ut not resulting in	n the un	derlying cause giv	en in Part I.	23e.	1.0	co use contribute to			
0	been si should t	eted								-	-1	2 No 3 Pro	bably 4 Unknown		
		Completed		. =			-			24a.	Was an autopsy performed of 2X	prior to condeath?	opsy findings available ompletion of cause of		
1	sician: certifica irector, p	o Be	25. Was case referre examiner? 1 (X) Yes 2 \(\subseteq \) N	1	Hospital:			2□ DOA Oth	0.0	of Death Check	The second				
ō	ernys erthis eral di	\vdash	27. Manner of Death		28a. Date of Injur	y 28b. 1	Time of	28c. Injun	4 🗀 (Yu)			6 Other (Spec	(fy)		
	ath. or: After he funer	atlo	1 X Natural 2 ☐ Accident	5 Pending investigation		/ Year)	njury		k? Yes 2 □N	ło					
Division	rs after de al Directo ed in by ti	Certification:	3 Suicide 4 Homicide	6 Could not be determined	28e. Place of Injubuilding, etc	ry - At home, fa c. (Specify)	ırm, stre	et, factory, office		28f. Loca City	tion (Street or Town, St	t and Number or Rui tate)	al Route Number,		
	to the nospitel or Attending Priystcian; within 24 hours after death. To the Funaral Director: After this certification; completely filled in by the funeral director.	Medical	2 Certifier Check only ane)	Certifying Phy Medical Exam	iner: On the basis of and manner sta	examination an	d/or inv	occurred at the linestigation, in my o	ria, date and pinion, death	place, and due to hipocourred at the	the caus time, date	a(e) and manner as and place, and due	stated. to the cause(s)		
i	Tot	2	29b. Signature and to	$\gamma 14$			•	29c. Licens	- 5/-			Date signed (Month			
Z	11		30. Name and addre	17/08	lecker	do sul	16	1) 5	ロクナ	20	00	ctober 1,	2007		
-	,000		1 va V	is of person who	mpleted cause of do	eath (Item 23a)	(Туре, Ғ	Print) ス(ワ)	D	the cont		20902			
	Sta Registr		31. Date filed (Month	, Day, Year)	32 Registra	ar's Signature	Can	Ve.	1) "		734			

07-07311 Joel Anthony Taylor

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2007 33193

oci / ilitilotiy Tuyii		For State Cer	tificate of Death	Reg. N	0.	
Physician	/ 1	egistrar Decedent's Name (First, Middle,Last)		Date of Death Month Da	y Year	3. Time of Death 1119 hrs
ledical Examine		Joel Anthony Taylor	4b. City, Town, or Location of Death	September 19	9, 2007 4c. County of Death	
	4	la. Facility Name (if not institution, give street and number) 4394 Pyrite Court	Middletown		Frederick	
E	F	5. Social Security Number 6. Sex 7. Age (In yrs. In		8. Date of Birth(M	M/DD/YYYY) 9. Birt	hplace (State or
Funeral Director		216-13-8402 1XM 2F 27	Yrs. Months Days Hours Mir	July 13	1980 ^{Cou}	nuntry) Mich.
		Usual Residence of Decedent 10a. State 10b. County 10c. City,	Town or Location			10d. Inside City Limits
*		MD Frederick	Middletown			1 Yes 2 XNo
Maryland 28a-f show	Director	10e. Street and Number	10f. Zip Code	10g.	Citizen of What Cour	ntry?
th the Maryland 23a or 28a-f sho notified at once.		4394 Pyrite Ct.	21769		USA	
ms 23	= 1	11. Marital Status 12. Was Decedent Ever in U	.S. 13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert	pecify Yes or No- p Rican, etc.)	White, etc.	can Indian, Black,
r death	되	X Never Married 2 Wallied 1 Yes 2 X No	1 Yes 2 X No specify:		Specify: Wh.	ite
	ਨ -	Widowed 4 Divorced If Yes, Give Year or Dates: 15. Decedent's Education (Specify only highest grade completed)	16a. Decedent's Usual Occupation (Give kind of		b. Kind of Business/	
2 hou	- ted	Elementary/Secondary (0-12) College (1-4 or 5+)	during most of working life. DO NOT use re	tired)		w 1100 1
5-0036 iled within 72 Hygiene. Joher than "	Completed	12	unemployed		none	
215-0036 be filed within 7 ntal Hygiene. rked other than ent, the Medica		17. Father's Name (First, Middle, Last) Ronald A. Taylor	18.Mother's Nam Eliza	ne (First, Middle, Maio beth K.	Scarrow	
2121 vuld be fill Mental I marked	To Be	19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or	Rural Route Numbe	r, City or Town, State	e, Zip Code)
, MD 21215-0036 and 2 should be filed within 72 feath and Mental Hygiene, ten 27 is market other than "rraumatic event, the Medical	-	Ronald Taylor (Father)	4394 Pyrite Ct.,	Middleto	own, MD	21769
Feeth Fitem		200. 1110/140 0. 2.0/1411111	Place of Disposition (Name of cemetery, crematory or other place)		0c. Location - City or	1
MOCE Pages 1 lent of 1 ant: If i		Donation 5 Other Specify:	utheran cemetery 9/			
Baltimore, permit, Pages I at Department of He Important: If ite injury or other in	(21. A gnatule of Fundan Service Ullensee	220 Years and Address of Facility on	pson Fur	neral Ho	me 21760
	1	13- Part I Enter the disease, or complications that caused the deat	P. O. Box 18,			Approximate Interval
Physician /Medical		failure. List only one cause on each line.				Between Onset and Death
caminer		Immediate Cause (Final disease or condition resulting in death) a. Methodore Intermediate Total Due to (or as a consequence	exication			
		Sequentially list conditions, b				
	iner	If any, leading to immediate Due to (or as a consequence cause. Enter Underlying Cause	of):			
: Lu	Examine	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence	of):			
	al E	d23a_27.	28a-f per meo g872 10-17-07	vt		
60, ate be ex ohysician ne burial	edical				23d. Date of delive	ırv
	≥	IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcome of pre	gnancy 2 Fetal death 3 Ectopic preg	nancy		Day Year
x 6 th cert ttendii	sician/	past 12 months? 1 Yes 2 No 9 Unknown g Unknown				
Records, P.O. Box 68760, The law requires that the death certificate be execunicate has been signed by the attending physician and page 2 should be detached for use as the burial - tra	Phys	Part II. Other significant conditions contributing to death but not	resulting in the underlying cause given in Part I.	23e. Did toba	acco use contribute t	o the cause of death?
P.O.	by	Part II. Other significant conditions		1 Yes	2 No 3 Pro	obably 4 V Unknown
ds, duires	ited			24a. Was an		autopsy findings available completion of cause of
COF	Completed			perform	ed? death?	
Re :: The jificate or, pag		25. Was case referred to medical	26.Place of Death (Che	10-11		
f Vital Physician: er this certifi	o Be	examiner? 1 V Yes 2 No Hospital: 1 Inpatient 2	ER/Outpatient 3 DOA Other Nu	sing Home 5 R	esidence 6 🗸 Oth	er: Scene
of Vital Records, P.O. Box 68: ing Physician: The law requires that the death certificate has been signed by the attending luneral director, page 2 should be detached for use as	-	27. Manner of Death 28a. Date of Injury (Month, Day, Year)	28b. Time of Injury 28c. Injury at Work?	_	w injury occurred	
Sion tttendir death. ctor: A	atio	Natural 5 Pending 9-19-07	11:11am 1 Yes 2 X No	unknown	151 152	Burel Pouto Number City
Division of Vital Records, P.O. Box 68 tall or Attending Physician: The law requires that the death certifiers after death. at Director: After this certificate has been signed by the attending led in by the funeral director, page 2 should be detached for use as	Certification:	3 Could not be 28e. Place of Injury - At	nome, farm, street, factory, office building, etc.	or Town, Sta	ite) 4354 Pyr	
Die Hospital		4 Homicide	edge, death occurred at the time, date and place,	Middleto	n, Ml. 2176	ated.
Division of Vital Rec To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate I completely filled in by the funeral director, page	Medical	one) 2 Medical Examiner: On the basis of examination	and/or investigation, in my opinion, death occurre	ed at the time, date a	nd place, and due to	the cause(s)
To the within To the comple	Med	and manner stated. 29b. Signature and title of certifier	29c. License number		29d. Date signed (A	
		Moline harris 00 M	O.C.M.E.		September 20,	2007
		30. Name and address of person who completed cause of death (It				
\emptyset		Melissa Brassell, MD Assistant Medical Exan		1D 21201		
St Regist	ate	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	ature			
44.0164			a mark			

				State of Ma	aryiano		tificata o	Health and r If Death	vierilai my	Reg. No.	UI	33194
	Dhusisian	1. Decedent's Name (Firs	t, Middle, Last)				******	2. Dete of De Month	Dev	Year	3. Time of Death 0500am
	Physician /Medical	RICHARD PRE						4b. City, Town, or I	09-26-		of Dooth	OSOOalli
)	Examiner	4a Fecility Neme (If not in MCREADY MEM	-					CRISFI	ELD	SCMERS		э.
3	Funeral Director	5. Social Security Number 214–36–5020 Usuel Residence of Dece	15	x 7. Age 2 F 68	e (In yrs. las	t birthday) Yrs.	If Under 1 Ye Months Day		8. Date of Bir (Month, Da 04-12-3	rth ay, Ye <i>ar)</i>	9. Birthp Coun MARY	place (State or Foreign htry) LAND
	/lend		County		10c. City,	Town or Lo	cation				1	0d. Inside City Limits
	a-f sh	MD SOI	MERSET	CO.	CRISF	IELD						Yes 2□No
	offer death with the Mark terms 23s or 28s-fs	10e. Street end Number 197 SOMERS	COVE AI	PTS.			10f. Zip Code 21817	Ð		10g. Citizen of V USA	Vhet Coun	try?
020	by	11. Marital Status 1 Never Married 2 3 Widowed 4 D		12. Was Decedent E Armed Forces? 1 ☐ Yes 文文 N If Yes, Give Year or Dates:			Was Decedent of If Yes, specify C	of Hispanic Origin? (Suban, Mexican, Puert No Specify:	pecify Yes or No o Rican, etc.)	Blac	e - Americk, White,	
Maryland 21215-0020	ed within 72 ho ygiene. Wer than "naturi it, the Medical I		ecedent's Edu ly highest grad (0-12)		+)	life.	DO NOT use ret	cupation ne during most of wor ired)	rking	16b. Kind of B		
2	iled w tygier nt, m	10 17. Father's Neme (First,	Middle Last)			RAB (COOKER	18. Mother's Nar	ne (First, Middle	, Maiden Surnan		SIKI
and	Mental H Mental H arked ott artic ever		BYRD					LILLIAN				
Mary	nd 2 shoulth and M 27 la mari	19a. Informant's Name/R KIM COLLINS	elationship (T					eet and Number or Ru CRISFIELD			State, Zip	Code)
Baltimore,	permit. Pages 1 end 2 should be filed within 7 Deportment of Health end Mental Hygiene. Important: If Nem 27 la marked other than "n any injury or other traumetic event, the Health and the Complements of the Mental Mental	20a. Method of Dispositio 1 Deputies 2 ☐ Created 4 ☐ Donation 5 ☐ C	mation 3 🗆 l	Removal from State	20b. Placen	oe of Disponence PEER	esition (Name of matory or other I CHURCH	ceneral CEMETERY	Date 10–6–07	20c. Location -	City or To	wn, State LAND
Balt	permit. Deperting any inju	21. Signature of Funeral	Service Licens	see		BE	2. Name and Ad NNIE SM	dress of Facility ITH FUNERA		917 W.]		
1 3	Physician /Medical Examiner	23a. Part1. Ener the dis- shock, or near failu Immediate Cause (Final disease or condition resulting in death)	ease, or comp ire. List only o	a		LUN	G CAI		o i respiratory t		1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Approximate Interval Between Onset and Death
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			- 6	d								
. Box	death d for a	Part II. Other eignificent	conditione co	ntributing to death bu	ut not result	ing in the u	inderlying cause	given in Part I.	23b. Dio	I tobecco use co	ntribute to	o the cause of death?
, P.O.	that the death certing by the attending deteched for use to be by Physician/M			ASCV					1)2	Yes 2□ No	3 🗌 Pro	bably 4 ☐ Unknown
Division of Vital Records,	The law requires that the death certiful has been signed by the attending page 2 should be deteched for use a Completed by Physician/M					-				s an autopsy ormed?	av	fere autopsy findings railable prior to impletion of cause death?
Re	The law ete has pege 2								- 10	Yes 2 Xuc	1[□Yes 2□No
/ita	ysician: The list certificate had director, page	25. Was case referred to examiner?	-	11	,				ath (Check only	one)		Ne:
ot	Physician: rthis certific and director.	1 ☐ Yes 2 No 27. Manner of Death		Hospitel: 1 Inpatie	- Contract C	R/Outpatie	nt 3LI DOA			idence 6 Oth how injury occur		·ý)
o	Attending I or death. ector: After by the fune iffication		Pending investigation	(Month, Day		Injury		njury at Work? 1 □ Yes 2 □ No		. ,		
Divisi	tal or Attending Physis effer death. In Director: After this ed in by the funeral di		Could not be determined	28e. Place of Injubulding, etc.	ury - At hom c. (Specify)	e, farm, st	reet, factory, offi	ice		(Street and Numbown, State)	ber or Run	al Route Number,
	Hospit 4 hours Funer tely fill	29a. Certifier 1 (Check only 2 II	Certifying Phy Medical Exam	relcian: To the best of iner: On the basis of and manner sta	examinatio	edge, deat n end/or in	h occurred at the	e time, date and place ny opinion, death occu	e, and due to the urred at the time	e ceuse(s) and m , date and place,	anner as s and due t	stated. o the cause(s)
	To the I To the Complet	29b. Signature end title o	certifier	V +	Karin	busate	D	ense number 48098		29d. Date signe		* * * * * * * * * * * * * * * * * * * *
	08M	30. Name end address of	person who o	ompleted cause of d	-6							
	State	201-Hall Hu 31. Date filed (Month, Da	y, Year)	Stield, MD a	<i>218/1</i> ar's Signatu	re	Sarolle					
	Registrar	SE	P 28	2007	may.	1						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 . Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** 6:30 ^{p M} Marie Louise Tylor September 26, 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Holy Cross Hospital Montgomery Silver Spring If Under 1 Year If Under 24 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 M 2 KF Director 578-38-8997 76 July 27, 1931 Washington, Usual Residence of Decedent 10c. City, Town or Location 10a. State 10h. County 10d. Inside City Limits show Hygiene. other than "natural" or items 23a or 28a-f shov ent, the Medical Examiner must be notified at 1 ☐ Yes 2 € No Director Maryland Montgomery Silver Spring 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code with 1 506 Beacon Road 20903 Funeral USA filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian 11. Marital Status Black, White, etc. 1 ☐ Never Married 🔏 😾 Married 1 ☐ Yes 2 ☑ No Specify: White 2 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) .. Pages 1 and 2 should be filed wi trrent of Health and Mental Hygien tant: If item 27 is marked other th jury or other traumatic event, the Bookkeeper Mosler Safe Co. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Bernard Lehmann Ethel Margaret Welch 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 Is any Injury or other trau once. 506 Beacon Road, Silver Spring, MD 20903

e of Disposition (Name of Date 20c. Location - City or Town, State Payl Byrne Tylor/Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Oct. 1. Gate of Heaven Cemetery Silver Spring, Maryland 2007 21. Signature of Funeral Service Licensee 22. Name and Address of Facility.
Francis J. Collins Funeral Home Inc. 500 University Blvd, W, Silver Spring, 23a. Part/ Errer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock or heart failure. List only one cause on each line. MD 20901 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Cardiopulmonary Arrest /Medical Due to (or as a consequence of): **Examiner** Metastatic Transitional-Cell Cancer of the Kidney Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence on Examine law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Physician/Medical as IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) the 9☐Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Hyponatremia, Dehydration 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has b irector, page 2 sl autopsy performed? 1□ Yes 2 No 1 ☐ Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2X No 1X Inpatient 2 ER/Outpatient 3 DOA P 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 5 ☐ Pending investigation Injury (Month, Day Year) 1 🖾 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

Box 68760, P.0. Records, Division or Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director; After this certifica completely filled in by the funeral director, p

Maryland 21215-0036

Baltimore,

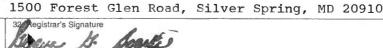
State Registrar

Medical

(Check only one)

29b. Signature and title of certifie

Smitha Bhikkaji, MD 31. Date filed (Month, Day, Year) 0CT 0 1 2007



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



1 Excertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D64100

29d. Date signed (Month, Day, Year)

September 27, 2007

Second Second Power of Name (not institution) gives arrest and number) Ab. CRIBBOT of Control of Power of Name (Not Name) Ab. CRIBBOT of Control of Power of Name (Not Name) Ab. CRIBBOT of Control of Power of Name (Not Name) Ab. CRIBBOT of Control of Power of Name (Not Name) Ab. CRIBBOT of Control of Power of Name (Not Name) Ab. CRIBBOT of Control of Name (Not Name) Ab. CRIBBOT of Control of Name Ab. CRIBBOT of Name (Not Name) Ab. CRIBBOT of Name	. Ensure All Copies Are Legible.													
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Tuttord Tutt	Date of Death Month Day Year 3. Time of Death				Last)	ne (First, Middle, La	1. Decedent's Nam	_	Physicia					
Social Security Numbers Social Security		or Location of Death	4h City-Town o	res				al	/Medica					
19 20 20 20 20 20 20 20 2		row!	Hagei	ł				er	Examine					
Document The properties The proper	Hours Min. (Month, Day, Year) Country)	Hours Min.	Months Days				1							
23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Physician Medical Examiner The disease or condition and disease or condition resulting in death) Sequentially list conditions, list caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Due to (or as a consequence of): Condition of the consequence of): Due to (or as a consequence of): Condition of the consequence of): Condition of the consequence of): Due to (or as a consequence of): Condition of the consequence of): Due to (or as a consequence		Ţ.				of Decedent	Usual Residence o							
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Physician // Medical Examiner 23a. Part! Errier the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. A WIR Respiratory Failure Immediate Cause (finish disease) or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury) that inflated events resulting in death) Last Due to (or as a consequence of): CNAC OSAC Character Curry Due to (or as a consequence of): CNAC OSAC Character Curry Due to (or as a consequence of): CNAC OSAC Character Curry The past 12 penths? 10 Yes 20 No 3 Probably Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Part II. Other	Dedutter remercial nome	Dead		- Com	censee _	Funeral Service Vice	21. Signature of F		Depar Impor any in once.	permit				
Physician / Medical Examiner The dical Examin	ing, such as cardiac or respiratory arrest, Approximate Interval Between			the death. Do	omplications that caused nly one cause on each lir	the disease, or coreart failure. List only	23a. Part1. Enter shock, or he							
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1 Sulvarono D34975 9/26/07	34975 9/26/07	34975				1 /0+	July.			^				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ralph Salvagno 11110 Medical Campus Road, Hagerstown, MD 21742	ad, Hagerstown, MD 21742	ıd, Hagerst	(Type, Print) L Campus Roa	Medica Medica	no completed cause of do	dress of person who Salvagn o	30. Name and add		-	2				
State 31. Date filed (Month, Day, Year) Registrar OCT 0 2 2007 32 Registrar's Signature			Sporte	rar's Signature	2007 32 Registr									

			1 - For State Registrar		State of Ma	aryland	d / Depa <i>Cei</i>	artment of H rtificate of I	lealth and M D <i>eath</i>		giene () (Reg. No.)7	331	97
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	/Medic Examin				ive street and number)		V 181		Location of Death	Береспье	4c. County		11.45 M	
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	Funeral Director		5. Social Security No. 577–72–222	umber 6. 5	Sex 7. Ag	67 (In yrs. la	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir Nov. 24,	th 1939		olace (State o ntry) amaica	r Foreign
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	the 7	Director	10e. Street and Nur		20186.5			10f. Zip Code			10g. Citizen of W	Vhat Cou	ntry?	
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215-0036	d within 72 hours after death with the Maryland giene. Ir then "naturel", or Itema 23a or 28e-f ehow the Medical Examinar must be notified at	by Funeral	11. Marital Status 1 Never Marri 3 Widowed	ed 2∰Marned 4 □Divorced	12. Was Decedent Armed Forces? 1 Yes 2 1 1 If Yes, Give Year or Dates:			Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ANo	ispanic Origin? (Sp in, Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)	14. Race Blac Specify	k, White,	can Indian, etc. Black	
ر ک	72 ho	eted	(Spec	15. Decedent's I	Education rade completed)		16a. Dece	dent's Usual Occup kind of work done of DO NOT use retired	ation during most of work	ring	16b. Kind of Bu	siness/In	dustry	
7	within ne. hen *	Completed	Elementary/Seco		College (1-4or 5	+)	Data Er)		Banki	ina		
N 0	the tr		12 17. Father's Name ((First, Middle, Las	st)		Data II	ici y	18. Mother's Nam	e (First, Middle				
Maryland	Mentel Merked o	To Be	Allan	Maxwell	Weston				Glady	s Ivy	Rennalls			
aZ	shou and M s mar	_	19a. Informant's Na	•			19b. Mailin	ng Address (Street	and Number or Rui	al Route Numb	er, City or Town,	State, Zij	Code)	
	and 2 ealth of n 27 i		Thompson	Vigille /	Husband		4.	Kingsway Ro				207		
Baltimore,	permit. Pages 1 and 2 should be to Depertment of Health and Mentel Important: If item 27 is marked of any injury or other treumatic everges.		4 Donation	☐ Cremation 3 5 ☐ Other (Spec	**	Ce	. Nation	esition (Name of matory or other place nal Cemeter	10/06/		Suitland,	, Mary	and	
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S.	w requires that the de been signed by the should be detached	by	Part II. Other signif	icant conditions	contributing to death b	ut not resu	ulting in the u	nderlying cause give	en in Part I.		obacco use contr Yes 2 ☐ No	ribute to t		death? Unknown
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<u></u>	Attending Fir death. ector: After by the funer.	atlo	t XXNaturat 2 Accident	5 Pending investigation	(Month, Da	y Year)	Injury		K? Yes 2 □ No					
Division of	or Al	Certification:	3 Suicide 4 Homicide	6 Could not determine				reet, factory, office		28f. Location (City or To	Street and Numb wn, State)	er or Rura	al Route Num	nber,
	5 4 7 9 9	edical	29a. Certifier (Check only one)	1. Certifying F 2 Medical Ex	Physician: To the best sminer: On the basis of and manner sta	examinat	wledge, deat tion and/or in	h occurred at the tin vestigation, in my o	ne, date and place, pinion, death occur	and due to the red at the time,	cause(s) and ma date and place, a	nner as s and due t	stated. o the cause(s	5)
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)	(a		30 Name and addr	ass of pareon wh	o completed cause of d	eath (Item	23a) /Tuno				10-2	2	200 t	
_	(3)		H. Herb	ert Washin	gton MD	11701	Livings	ston Road	#205 Ft. Wa	ashington	, Maryland	<u>l</u> 20	1744	
	Sta Registr		31. Date filed (Mon. OCT 0	2 2007	Figure D	ars Signal	out !							

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Sonia VARSANO **Physician** \$eptember 30, 2007 6:30 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery 6908 Marbury Road Bethesda If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 4 Under 26, 19 Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 X F Brazil 1945 Director 62 Usual Residence of Decedent r 28a-f show notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2 No Bethesda Maryland Montgomery Director 10f. Zip Code 20817 10g. Citizen of What Country? 10e. Street and Number an "natural", or items 23a or Medical Examiner must be Brazil 6908 Marbury Road death v Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status d 2 should be filed within 72 hours after th and Mental Hygiene.
7 is marked other than "natural", or ite traumatic event, the Medical Examine 1 ∏ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: white Specify \$ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Sociology Professor University 5+ 17. Father's Name (First, Middle, Last)
Shalom Rozental 18. Mother's Name (First, Middle, Maiden Surname)
Eva Gruman Be 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health and Important: If item 27 is n any injury or other traun once. 6908 Marbury Road, Bethesda, MD 20817 Ricardo Varsano, Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Mt. Lebanon Cemetery 10/01/07 Adelphi, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Torchinsky Hebrew Funeral Home 254 Carroll St., NW, Washington, DC Approximate Interval Between Onset and Death Years 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Breast Cancer disease or condition resulting in death) /Medicat Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause Enter Underly in Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 ☐ Ectopic pregnancy Month Year Day 4☐Pregnant at time of death signed by the at d be detached fo 5 Other (specify) 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 🛣 No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2X No 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After 1 Certification: 1 X Natural 5 ☐ Pending investigation To the Hospital or Attendia within 24 hours after dearh. To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D 23600 October 1, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bruce Kressel, M.D., 5530 Wisconsin Ave. #1125, Chevy Chase, MD 31. Date filed (Month, Day, egistrar's Signature State 0 2007 OCT Registrar

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Division or Vital Records, P.O. Box 68760, the !

Baltimore, Maryland 21215-0036

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death - Month Year **Physician** restender 0:00 200 Mildred Elliott Weller /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Washington Washington County Hospital Hagerstown If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 🗓 F Director 94 May 3, 1913 West Virginia 236-62-5901 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 ☑ No Director MD Boonsboro Washington 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 313 Lanafield Lane 21713 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 □ Yes 2 No Specify: þ White 3 Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) +2 Teacher <u>Education</u> 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Harry Horner Vernie Harrison ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Joseph Elliott/Son 22029 MohawkDr., Smithsburg, MD Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Edge Hill Cemetery 4 □ Donation 5 □ Other (Specify) 10/1/2007 Charles Town, WV 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rest Haven Funeral Chapel S. Mar 1601 Pennsylvania Ave., Hagerstown, MD 21742 23a. Part1. Enter the disease, or complicates that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 2 No Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 2 No Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifica Be (25. Was case referred to medical examiner? 26. Place of Death (Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 21 No 1 Inpatient 1 Yes 2 ER/Outpatient 3 DOA 27. Manyler of Death Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the Hospital within 24 hours at To the Funeral C to the cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

□ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier leted cause of death (Item 23a) (Type, Print) 30. Name and address of person who com Keedysville Wyand bueden 2. Registrar's Signature 31. Date filed (Month, Day, Year) State OCT 1 6 2007 Registrar

			1 - State of IV Registrar	aryiand /		ificate of i	ieaith and ivi Death		$_{\text{Reg. No.}}^{\text{lene}} 200^{\circ}$	7 33200
2	Physici	an	1. Decedent's Name (First, Middle, Last)	, –	_			2. Date of Dea	Day Year	3. Time of Death
10.00	/Medic	cal	4a. Facility Name (If not institution, give street and number		V.	4b. City. Town, o	r Location of Death	Octobe	4c. County of Dea	1 2:49 AM
	Examir	ıer	Laurel Regional t	lospita	1.15	haus			Prilee	George's
	Funeral Director		5. Social Security Number	ge (In yrs. last i	birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day Dec. 1.	9. Bir 7, Year) 3 1 952 Flor	thplace (State or Foreign ountry) cence, S.C.
	yland iow at		Usual Residence of Decedent 10a. State 10b. County New	10c. City, To	own or Loca	tion				10d. Inside City Limits
	e Man la-f sh tifled	ctor	Jersey Union	Lin	den					1 TYes 2 No
	vith th	Dire	10e. Street and Number 510 Briant Place			10f. Zip Code	36-2571		10g. Citizen of What C United St	-
	ns 23	Funeral Director	11. Marital Status 12. Was Deceden Armed Forces	t Ever in U.S.	13. W		ispanic Origin? (Spe an, Mexican, Puerto	cify Yes or No-		
21215-0036	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiliner must be notified at	d by Fur	1 □ Never Married 2 □ Married 1 ☑ Yes 2 □ If Yes, Give 3 □ Widowed 4 ☑ Divorced Year or Dates:	No	1[∃Yes 2⊠No	Specify:	Rican, etc.)	Specify: B	lack
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Maryland	2 should be and Mental is marked or raumatic ever	ပ	Charlie Williams, Sr. 19a. Informant's Name/Relationship (Type. Print)	1	Oh Mailing	Address (Street		e Lewis	er, City or Town, State,	Zin Cada)
Ma	1 and 2 sho Health and em 27 is ma		Torriano Williams/Son	ı					nce, SC 295	
Baltimore,	permit. Pages 1 and Department of Health Important: If item 27 any injury or other to		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		rans	tion (Name of atory or other place Cemetery	10–9-	- 1	20c. Location - City of Florence, S	o.Carolina
3alti	permit. Pa Departmer Important: any injury once.		21. Signature of Funeral Service Licensee	01.2-			_		al Homes,	
	40 = 40		23a. Part . I ter the diseas or complical ins that cause shock, or heart failure ist only one cause on each	ed the death. D						yland 20747 Approximate Interval Between
B	Physician		shock, or heart failure. List only one cause on each Immediate Cause (Final disease or condition	line.	cta	vu T	miline			Interval Between Onset and Death
1	/Medical Examiner		resulting in death)	s a cons queno	ce of):	1	T 1			Almores
B	Examiner	Į,	Sequentially list conditions, b. Due to (or a	s a consequence	C (C	1101469	talliv	e		years
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	NEVOS	1/8	votic	Hear	t Di	Sease	Year C
o,	e execian and	Еха	resulting in death) Last Due to (or a	s a consequenc	ce of):					
68760,	tificate be executed g physician and as the burial-transit	edical	d							
P.O. Box 6	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Me		e pf pregnancy 2 □ Fetal dea at time of death	ath 3□E	ictopic pregnancy Other (specify) _	/		23d. Date of de Month	Plivery Day Year
	uires that sign e d b d be deta		Part II. Other significant conditions contributing to death	but not resulting	g in the und	erlying cause giv	en in Part I.		obacco use contribute t	
or Vital Records,	aw requir s been si should	Completed by						24a. Was a	an 24b. Were a	autopsy findings available
l Re		omo:						autop perfor 1∏ Yes	rmed? prior to death? 2 \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	
/ita	Physician: Th this certificate ral director, pac	Be	25. Was case referred to medical examiner?			To:	26. Place of Death			
or	Physrathis ral dir	. To	1 ☐ es 2 ☐ No Hospital: 1 ☐ Inpat 27. Manner of Death 28a. Date of In		Outpatient b. Time of	3 □ DOA Oth	4 LI Nursing Hor	-	lence 6 Other (Spenow injury occurred	ecify)
ion	nding Pł uth. r: After the funeral	ation	1 ☑ Actional 5 ☐ Pending (Month, D 2 ☐ Accident investigation		Injury	28c. Injur Wor M 1 🗆	k? Yes 2 □ No		ou mjary occurred	
Division	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Certification:	4 Homicide determined building, a	tc. (Specify)		et, factory, office		City or Tow		
	To the Hospital within 24 hours a To the Funeral completely filled	Medical	29a. Certifier 1 Certifying Physician: To the bes cone) 2 Medical Examiner: On the basis and manner s	of examination	dge, death and/or inve	occurred at the tirestigation, in my c	me, date and place, a opinion, death occurr	and due to the o ed at the time,	cause(s) and manner a date and place, and du	s stated. se to the cause(s)
	Vith To t	Σ	29b. Signature and title of certifier			29c. Licens	e number		29d. Date signed (Mon	
7	(2)		20 Name and address of person who completed course of	Coath (Itam Co	o) /T/m = D	1)50	0418		Uctober	12001
R	-(3)		30. Name and address of person who completed cause of K. Towya. Mason. 73	DO Va	(V)		d, Lour	el MJ	2070	1
	Sta Registr		31. Date filed (Month, Day, Year) OCT 0 2 2007	trar's Signature	de				· · · · · · · · · · · · · · · · · · ·	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 27,28a-f per me, g8/2,10/11/0/dhb.

Reg. No.

Reg. No. 1 - For State Registrar Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Betty Month 9 **Physician** Lee Welborn a3 2048 PM 2007 /Medical 4b. City, Town, or Location of Death 4c. County of Death Facility Name (If not institution, give street and number) Examiner (1) icomico ENINSULA KEGIONAL MEDICAL CENTER ALISBURY If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours Months Min. 1 □ M 2 🕱 F Yrs. 309-24-4635 82 Director 5/1/1925 Indiana Usual Residence of Decedent 10c. City. Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show Examiner must be notified at 1 ☐ Yes 2 XNo Director Maryland Wicomico Salisbury 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 5 1227 Orchard Circle 21801 USA 'natural", or items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: ģ Specify. white 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygien Important: If Item 27 is marked other the any Injury or other traumatic event, the once. homemaker domestic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Twila Creek James Hughes ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William J. Welborn/son 78 Belleville Rd., Parsippany, NJ 07054 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a, Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 9/25/07 Salisbury, MD Salisbury Crematory ²², Name and Address of Facility Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 21. Signature of Funeral Service-Herth (FSP 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final (GARZEENNEUR GOLD 15lb) disease or condition resulting in death) /Medical Due to (or as a consequence of) CATICAL EXAMINER Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria CERT Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA P this 28a. Date of Injury (Month, Day Year) 27. Manner of Death

VEINatural

2 Accident 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Injury 5 Pending investigation 09/08/07 Unknown M 1 ☐ Yes 2 ▼No Subject fell 3 ☐ Suicide 6 ☐ Could not be

Physician Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, after death. in by the f within 24 hours a

309-24-4835

with the Maryland

Baltimore, Maryland 21215-0036

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

determined

Home

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

29c. License number

28f. Location (Street and Number or Rural Route Number, City or Town, State) 1227 Orchard Circle

Salisbury, MD Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Drz

036576

Rusniele

29d. Date signed (Month, Day, Year)

30. Name and add ss of person who completed cause of death (Item 23a) (Type, Print) KOWALD

2007

P. ROWITZ egistrar's Signature

360

State Registrar

Medical

4 ☐ Homicide

(Check only one)

31. Date filed (Month, D

29a. Certifier

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 0 7

1- State Amend 28d&f, perME, g872, 10/39/07 TT Certificate of Death

Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Physician Eva Mae White 41 PM September 26,2007 /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner ST. Agnes HOSPITA Baltimore If Under 1 Year | If Un Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year June 20, 1 5. Social Security Number 9. Birthplace (State or Foreign 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Hours 126-01-2655 1 □ M 2 🕅 F 90 New York Director Usual Residence of Decedent 10d. Inside Cify Limits 10c. City, Town or Location 10a, State 10b. County 1 ☐ Yes 2 No MD Howard Ellicott City Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21043 USA 3004 North Ridge Road permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: if item 27 is marked other than "naturar", or Items 23a any Injury or other traumatic event, the Medical Examiner must any Injury or other traumatic event, the Medical Examiner must once. Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2XXXNo Specify: White Specify. ş 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Own Home College (1-4or 5+) 12 Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ernest Gleason Ross Ora Mae Yost ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Tracy Newhouse/granddaughter 570A Center Drive, Severna Park, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Ft Lincoln Cemetery 9/29/07 Brentwood, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Sign 22. Name and Address of Facility 4739 Baltimore Avenue 373 Gasch's Funeral Home, PA Hyattsville, MD 20781 23a Part1. Enter the disease, or omplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 10 days **Physician** Spine CRYICAL disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner spinal cord compre Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence or). Examiner aspiration Dreumonia REPROPED BY HEDICAL Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1□Live birth 2□Fetal death
4□Pregnant at time of death ENTIFEATION 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1□Yes 2□No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 Yes 2 No 3 Probably 4 Unknown coronary artery disease Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Diabetes mellitus 24a. Was an autopsy perform Osteo porosis 1☐ Yes 2 No 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 □ Natural 2 🗷 Accident 5 Pending investigation 1 ☐ Yes 2 X No reptember 17,07 unknown en known-Subject fell 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3004 N. Ridge Rd. 3 ☐ Suicide determined 4 Homicide HOME Unknown Ellicott City, MD 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760,

with the Maryland

Baltimore, Maryland 21215-0036

show

23a or 28a-f

the Medical Examiner must be notified at

Eva white

completely filled in by the funeral To the Hospital within 24 hours at To the Funeral L State Registrar

this

After

after death.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 900 Caton 31. Date filed (Month, Day, Year) OCT 0 2 2007

29b. Signature and title of certifier

(Check only one)

Baltimore 32. Registrar's Signature

29c. License number

21229

29d. Date signed (Month, Day, Year)

			For State Registrer	State of Maryland		artment of Ho tificate of D			giene Reg. No. 2	07	33203
	Physici		Decedent's Name (First, Middle, Last Anna	Louise	I	Wahler		2. Date of Dea Month September	Day)7	3. Time of Death 4:15 P M
	/Medic Examin		4a. Facility Name (If not institution, give St. Mary's Nursing Cer 5. Social Security Number 6. Se	iter	ıst birthday)	4b. City, Town, or Leonard	town	8. Date of Birt	St. Ma	9. Birth	place (State or Foreign
	Funeral Director			⊒м 2 ДЖ 94	Yrs.	Months Days	Hours Min.	Sept. 24,	1913	Wash	fington, DC
	Maryland -f ehow	tor	10a. State 10b. County Maryland Calvert	,	, Town or Lo Leonar	_					10d. Inside City Limits 1 ☐ Yes 2 🖔 No
	Sa or 28a	Funeral Director	10e. Street and Number 7320 Bond Street			10f. Zip Code 20685			10g. Citizen of USA		intry?
036	permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other then "neturef", or items 23a or 28a-f ehow amy njury or other traumatic event, the Medical Examiner must be multied at Ance.	þ	11. Marital Status 1. ☑Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 KNo If Yes, Give Year or Dates:	-	Was Decedent of His If Yes, specify Cubar 1 ☐ Yes 2 ☑ No	spanic Origin? (Spo n, Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)	- 14. Ra Bla Speci	ack, White	ican Indian, , etc. nite
Maryland 21215-0036	within 72 ho ene. then "netur	Completed	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12)		life.	dent's Usual Occupa kind of work done d DO NOT use retired, maker	tion uring most of work	ing	16b. Kind of I	Business/Ir In Han	
land 2	uld be filed fental Hygi rked other tic event, I	To Be Co	17. Father's Name (First, Middle, Last)	nler				Lillian	Richard	ls 	
Mary	nd 2 shouth and N 27 is ma		19a. Informant's Name/Relationship (7) Harry C. Knott / Nephe			ng Address <i>(Street a</i> Bond Street					p Code)
Baltimore,	Pages 1 er ment of Hea ant: if item lury or othe		20a. Method of Disposition 1 ⊠ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Removal from State St.	metery, crer Mary's	osition (Name of matory or other place Cemetery	10/06/		Washingt	ton, D	C
Balt	Depart Import any in		21. Signatur of uneral Service Licen	96)	22	2. Name and Addres	^{s of Facilit} Georg Hill Road (e PA 0745
	Physician /Medical Examiner	ner	23a. Part1 Enter the disease, or companies, or companies, or heart failure. List only of the companies of th	b. Due to (or as a consequence of the death one cause on each line. Due to (or as a consequence of the death one cause on each line.	ience of):		g, such as cardiac			di	Approximate Interval Between Onset and Death
8760,	death certificate be executed e ettending physician and od for use as the burial-transit	dical Examin	Cause (Disease or injury that initiated events resulting in death) Last	C	ience of):				:		
.O. Box 68	death certif e ettending id for use a	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2₹₹No 9 ☐ Unknown	23c. If yes, outcome of pregna 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de	death 3	□Ectopic pregnancy				Date of deli	ivery Day Year
<u>α</u>	es the	þ	Part II. Other significant conditions of	ontributing to death but not resu	ulting in the u	inderlying cause give	en in Part I.		tobacco use co Yes 2 □ No		the cause of death?
Vital Records,	The law ate hes b page 2 sl	Completed						24a. Was auto perfo 1 - Yes		o. Were au prior to d death? 1 ☐ Yes	topsy findings available completion of cause of 2 No
	sicien: certific rector,	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ◯ No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatie	nt 3□ DOA Oth	26. Place of Deat	th <i>(Check only o</i> ome 5 ☐ Resi		ther (Spe	cifv)
ion of	After Une	-	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	of 28c. Injun Work		28d. Describe	how injury occ	urred	
Division		Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	ome, farm, st	reet, factory, office		28f. Location (City or To	Street and Nur wn, State)	nber or Ru	ural Route Number,
	To the Hospitei or within 24 hours effe To the Funeral Dir completely filled in	Medical	29a. Certifier 1. ⚠XCertifying Ph (Check only one) 2 ☐ Medical Exem	ysicien: To the best of my kno niner: On the basis of examina and manner stated.	wiedge, deat tion and/or in	nvestigation, in my o	pinion, death occur	, and due to the red at the time,	date and place	e, and due	to the cause(s)
	To the within 2 To the complete	Σ	29b. Signature and title of certifier	Jan Taru	0		YZYC		29d. Date sign		_
1	(4)		30. Name and address of person who's William D. Boyd	II MD 25365 Po	int Loo	, Print) kout Road Le	eonardtown,	Maryland	1 20650)	
	Sta Regist	ate rar	31. Date filed (Month, Day, Year) OCT 0 2 2007	32. Registrar's Signature D. Sp	ed)		· · · · · · · · · · · · · · · · · · ·				

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** Wilson Mae 2007 /Medical 4c. Oounty of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Chever! Georges County Hosp. ta Prince Georges 8. Date of Birth (Month, Day, Year) 9. Birthplac **Funeral** 1□M 2 F Director 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County or 28a-f show 1 Yes 2 No the Medical Examiner must be notified Director 10g. Citizen of What Country? 10e. Street and Number "natural", or items 23a by Funeral Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status ☐Yes 2 No 1 Never Married 2 Married 1 ☐ Yes 2 1 No 3altimore, Maryland 21215-0036 Black lf Yes, Give Year or Dates: 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) than, College (1-4or 5+) Seafood Industry Janitorial Work permit. Pages 1 and 2 should be filed Department of Health and Mental Hygir Important: If Item 27 Is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Sampson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Oakley Street Cambridge, Gloria 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Henry Funeral Home, P. A.
510 Washington St. Cambridge 21. Sign ure of FuneraLService Licensee 23a. Part . Enter the disease, or complications that caused the ath. Do not enter the mode of dying, such ck, or heart failure. List only one cause on each line. as cardiac or respiratory arrest Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical **Examiner** Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner and burial-trar Due to (or as a consequence of) signed by the attending physician be detached for use as the buria Physician/Medical as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? Month 4☐Pregnant at time of death 9☐Unknown 5 Other (specify) P.O. | 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 3 Probably 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an performed 2 No funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1☐ Yes 2☑ No 1 npatient 2 ER/Outpatient 3 DOA ၉ this 27. Manner of Death Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After t Hospital or Attending 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: completely filled in by the 6 ☐ Could not be 3 Suicide . Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certific cause of death (Item 23a) (Type, Print) 30 Name and address of person who completed 6 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** Priscilla wells September 27, 2007 0515 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Talbot Memorial Hospital Easton If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 12 F 89 214-52-0010 Director Florida May 6, 1918 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d, Inside City Limits 28a-f show traumatic event, the Medical Examiner must be notified at Trappe 1 ☐ Yes 2 PNo MD.Talbot 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? tems 23a or Ocean Gate Way

12. Was Decedent Ever in U.S.
Armed Forces? Z S A 14. Race - American Indian, Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Maritai Status Black, White, etc. 1 Yes 2 PNo
If Yes, Give
Year or Dates: 1 Never Married 2 Married ٥, 1 ☐ Yes 2 1 No Specify. Completed by 3 Widowed 4 ☐ Divorced Black natural 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Assistant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Maryland Be Richard Ihomas 4:14 Morris 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number of Rural Route Number, City or Town, State, Zip Code) Easton, Maryland 216
Date 20c. Location - City or Town, State P.O. BOX 106 -Kal 20a. Method of Disposition I
1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 21. Signature of Funeral Service Licensee

22. Name and Address of Facility

23. Part. Enter the disease, or complications that caused the leath. Do not enter the mode of dying, such as cardiac or respiratory arrest,

| Interest | Interest | Interest | Interest | Interest | Interest | Interest | Interest | Interest | Interest | Interest | Interest | Interest | Interest | Interest | Interest | Interest | Interest | Interest | Interest | Interest | Interest | Interest | Interest | Interest | Interest | Interest | Interest | Interest | Interest | Interest | Interest | Interest | Interest | Interest | Interest | Interest | Interest | Interest | Interest | Interest | Interest | Interest | Interest | Interest | Interest | Interest | Interest | Interest | Interest | Interest | Interest | Interest | Interest | Interest | Interest | Interest | Interest | Interest | Interest | Interest | Interest | Interest | Interest | Interest | Interest | Interest | Interest | Interest | Interest | Interest | Interest | Interest | Interest | Interest | Interest | Interest | Interest | Interest | Interest | Interest | Interest | Interest | Interest | Interest | Interest | Interest | Interest | Interest | Interest | Interest | Interest | Interest | Interest | Interest | Interest | Interest | Interest | Interest | Interest | Interest | Interest | Interest | Interest | Interest | Interest | Interest | Interest | Interest | Interest | Interest | Interest | Interest | Interest | Interest | Interest | Interest | Interest | Interest | Interest | Interest | Interest | Interest | Interest | Interest | Interest | Interest | Interest | Interest | Interest | Interest | Interest | Interest | Interest | Interest | Interest | Interest | Interest | Interest | Interest | Interest | Interest | Interest | Interest | Interest | Interest | Interest | Interest | Interest | Interest | Interest | Interest | Interest | Interest | Interest | Interest | Interest | Interest | Interest | Interest | Interest | Interest | Interest | Interest | Interest | Interest | Department of Federalsburg, Maryland Approximate Interval Between Onset and Death Immediate Cause (Final Preumonia **Physician** Aspiration disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Couprovasa Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine law requires that the death certificate be executed nding physician and use as the burial-tran Due to (or as a consequence of): or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery atten for us 3 □ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Vear 4☐Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Faile 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy performed? 1☐ Yes 2★ No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Kinpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA Medical Certification: To this 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After Hospital or Attending 1 Natural 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No To the Hospital or Attendi within 24 hours after death. To the Funeral Director; A completely filled in by the fu death. 2 Accident 6 Could not be determined 3☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

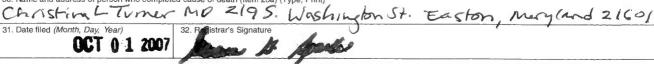
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day, Year)

OCT 0 1 2007

must 200

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



mo

D0066371

September 27,2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Day Ruth Lavina Willey <u>10:00a</u>.[™] 2007 /Medical Sept 28 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 4735 Harrisville Road Woolford Dorchester 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 □ M 2 X F 79 213-22-6143 Director June 25, 1928 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at Dorchester Woolford 1 ☐ Yes 2X No MD Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4735 Harrisville Road 21677 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status Baltimore, Maryland 21215-0036 $^{\prime\prime}$ 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: þ Specify: white 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) other than College (1-4or 5+) home maker own home 10 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) is marked John Henry Brannock Lula Fitzhugh 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If item 27 is Joseph Byrd Willey husband 4735 Harrisville Road, Woolford, MD 21677 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State injury 4 ☐ Donation 5 ☐ Other (Specify) Salisbury Crematory | 10/02/2007 | Salisbury, MD 21. Signatur of Funeral Service Licensee 22. Name and Address of Facility Thomas Funeral Home, P.A. hat Im 700 Locust Street, Cambridge, MD 21613 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Metastehic Physician Concer /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) physician and the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Physician/Medical by the attending platached for use as t as IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Year Month Day 5 Other (specify) 9 ☐ Unknown been signed by should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an s certificate has the sirector, page 2 s 25. Was case referred to medical Be 26. Place of Death (Check only one) nours after death.

neral Director: After this ce

filled in by the funeral direc Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) 1 Yes 2 No 2 27, Manner of Death 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Division or Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p

State

29b. Signature and title of certifier

NOMAN

31. Date filed (Month Day)

Registrar

DHMH 17 Rev 1/2001

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0 1 2007

THANWY

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

CAMBRIDGE MD 21613

29d. Date signed (Month, Day, Year)

9-28-07

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2007 33207

		1- For State Registrar		Cen	tificate of	Death			Re	eg. No.		
Physicia		Decedent's Name (First, Middl	le,Last)						Date of Deat	h		Time of Death
edical Exami	ner	JEANNE MARIE V	JIGGINS						Month Septembe	Day Yea er 26, 2007	ar i	0916 hrs
		4a. Facility Name (if not institution		nber)	4	b. City, Town, c	r Location o	of Death		4c. County	of Death	
		213 Slippery Hill Lane	•			Queenstov	vn			Queen A	\nne' s	
Funeral		5. Social Security Number	6. Sex	7. Age (In yrs. la	st birthday)	If Under 1 Ye	ar If Unde	er 24Hrs. 8	8. Date of Bir	th (MM/DD/YYYY		ace (State or
Director		215 06 5175	1 M 2 X F	42	Yrs.	Months Da	ys Hours		MADOII	c 1065	Foreign Country	^{y)} MARYLAND
		215-96-5175 Usual Residence of Decedent		4.4					MAKCH	6, 1965		MAKILAND
any		10a. State 10b. County		10c. City,	Town or Locati	on	• • •				10	d. Inside City Limits
<u>*</u>											1	Yes 2 X No
viaryland 28a-f show d at once	ţor	MARYLAND QUEEN 10e. Street and Number	ANNE'S	QUEI	ENSTOWN	10f. Zip Code				0g. Citizen of Wi	hat Country	?
ne Mar or 28a	Director											
with the Maryland ns 23a or 28a-f sho		213 SLIPPERY H				21658				UNITED		
ms ms	Funeral	11. Marital Status 1 X Never Married 2 M	arried 12. Was Deco	edent Ever in U.S rces?		s Decedent of H es, specify Cuba					e - American e, etc.	Indian, Black,
deal or it	Fun		1 Yes	2 X No							****	
after ral",	by		orced If Yes, Give Year or Dates:		1	Yes 2 X N					WHITE	
72 hours after death n "natural", or iten	eq	15. Decedent's Education (Spe				t's Usual Occup ost of working lif				16b. Kind of Bu	ısıness/inau	istry
16 n 72 ica∐	Completed	Elementary/Secondary (0-12)	College (1	-4 or 5+)								
5-0036 iled within Hygiene. I other than	m	12			HOMEMA	KER	40 14-15-	de Name (F	Cant Ministra	OWN HO		
Filed Hyged out		17. Father's Name (First, Middle	,					,		Maiden Surname	9	Ì
21215-0036 Juid be filed within 72 hours after death Mental Hygiene marked other than "matural", or ite marked other than "matural", or ite event, the Medical Examiner must	o Be	HARRY DANIEL W 19a. Informant's Name/Relations			T 10h Mailine	Addross (Ch.			SUTP	HIN nber, City or Tov	m Cinto 7	a Cada)
D 2 shoul and N r is m	ř				TV.	,						
nore, MD 2's and 2 should and M set of Health and M int. If item 27 is m.		MICHAEL WIGGINS 20a. Method of Disposition	5/BKUTHEK	20h F		ition (Name of c				ANNAPOL 20c. Location		
Ore SS 1 a Of Hk If its		1 Burial 2 X Cremation	n 3 Removal fro		rematory or oth		,,		BER 27		,	,
Page Page annest or ot		4 Donation 5 Other S	pecify:	СНЕ		E CREMA		20				E, MARYLAND
Baltimore, permit. Pages 1 an Department of He Important: If ite		21 Ig wure of Funeral Service	License	7/	22. N	lame and Addre	ss of Facilit	BEIN	AND N	EWNAM FU	INERAL	HOME, P.A
ш жава		Cal M.	16		` 110	6 SHAMR	OCK RO	DAD. (CHESTE	R. MARYI	LAND 2	1619
Physician		23a. Part I. Enter the disease, or failure. List only one cause	on each line						espiratory arr	est, shock, or he	art A	Approximate Interval Between Onset and
/Medical xaminer		Immediate Cause (Final disease	Coc	caine an	id fenta	anyl in	toxica	ation				Death
		or condition resulting in death)	Due to (or as a	consequence of	7):							
	<u></u>	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a	consequence of	٦.						$\overline{}$	
	ij	cause. Enter Underlying Cause		consequence of	,,						- 4	
	Examiner	(Disease or injury that initiated events resulting in death) Last	Due to (or as a	consequence of):				•			
executed an and al - transit			d								-+	
ାଳ ଖ [ି]	/Medical	X UNPENDED	AMENDED	tems: 2	3a,27	& 28a-f	per 1	MEO G-	-872 1	0/19/07	reb	
760, ficate be g physic the bur	/Me	IF FEMALE: 23b. Was decedent pregnant in the	23c, If yes, o	outcome of pregr	nancy					23d. Date o	of delivery	
68 ertifi ding	jan	past 12 months?		irth ant at time of de	- 44-		Ectopi	ic pregnanc	у	Month	Day	Year
Box 68760, e death certificate be the attending physici of for use as the buri	sic	1 Yes 2 No 9 🗸 Un			atn 5 Ot	her (Specify)						
	Physiciar	Part II. Other significant condit			esulting in the L	underlying cause	aiven in P	art I.	23e. Did t	obacco use cont	ribute to the	cause of death?
ords, P.O. I w requires that the as been signed by t	by	,			J	, , ,	J		1 Ye	s 2 No 3	Probab	ly 4 🗸 Unknown
S,		<u> </u>							24a. Was	an 124h	Were autor	sy findings available
Cord law rec has bee	Completed								auto	psy	prior to com	pletion of cause of
Pec	E O										death? 1 ✔ Yes	2 No
tal Rection: The certificate ector, page		25. Was case referred to medica	al		-	26.Pla	ce of Death	(Check on	ly one)			
Division of Vital Records, plate or Attending Physician: The law requirers ours after death. Reval Director: After this certificate has been similar in by the funeral director, page 2 should I	o Be	examiner? 1 ✓ Yes 2 No	Hospital: 1	npatient 2	ER/Outpatient	3 DOA	Other ₄	Nursing I	Home 5	Residence 6	✔ Other: S	cene
ing Ph After t uneral		27. Manner of Death	28a. Date	of Injury	28b. Time of I	`_`	jury at Wor	_	_	how injury occur	red	
on ath.	tio			(26707	9:04 Found	a.III 1	Yes 2	No	unkno	wn		
Division tat or Attendins after death. The Director: A led in by the fi	fica		290 Place	e of Injury - At ho		et, factory, office	building, e	etc. 28	8f. Location (Street and Num	per or Rural	Route Number City
Divi	Certification:		ermined (Specify)	found	at home	е			or Town, S Dueens	town, Mo	ттрbе Эттрре	ery HIII La
To the Hospital within 24 hours To the Funeral			hysician: To the bes	t of my knowleds	ge, death occui	rred at the time,	date and pl	lace, and du	ue to the cau	se(s) and manne	er as stated.	
To the Hos within 24 h To the Fur completely	Medical	one) 2 Medical Exa	aminer:On the basis	of examination a	nd/or investiga	tion, in my opini	on, death o	ccurred at t	he time, date	and place, and	due to the c	ause(s)
Writ Cor	Me	29b. Signature and title of certific	and manner s er	ated.		29c. Lice	nse number	r		29d. Date sig	ned (Month	, Day, Year)
6		Dot 1	0-10	1		0.0	C.M.E.			Septembe	er 27, 200)7
(44)		YOU LL	1000	Me MAD	230)							
「しん」		 Name and address of persor Patricia Aronica-Polla 		e of death (Item ant Medical E		111 Penn	Street. B	altimore.	MD 2120)1		
	tate											
Regis		31. Date filed (Month Sterpen)	8 2007 32. Re	strar's Signatu	J. A	north						

		For State Registrar	State of Maryla	-	artment of H <i>rtificate of I</i>		-	giene Reg. No 20	07	332	08
T = 1		Decedent's Name (First, Middle, Last)					2. Date of De Month		Year	3. Time of	
Physic /Med		Virginia L. W				4b. City, Town, or Location of Death			mber 26, 2007		P M
Exami	4a. Facility Name (If not institution, give street and number) Mandrin Chesapeake Hospice House				Harwo	_			ty of Death Arund	ام1	
Funeral Director		5. Social Security Number 6. S		s. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birl (Month, Da 2/9/192	h v. Year)	9. Birthpl	ace (State o	or Foreign
rland ow at		Usual Residence of Decedent 10a. State 10b. County		City, Town or Lo	ocation					d. Inside Ci	
a-f sh	ctor	Maryland Anne Ar	unde1		Edgewater	•				1 ☐ Yes	2 X No
or 28	Director	10e. Street and Number			10f. Zip Code			10g. Citizen o		ry?	
ath w	rall	127 Oakwood Road		11.0	21037		7 1/2	USA	ace - America	an Indian	
perillinities in the light of the control of the many permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event; the Medical Examiner must be notified at any once.	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 ☒ Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 🕅 No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 【 No	Ispanic Origin? (Span, Mexican, Puerto	ecity Yes of No Rican, etc.)	Spec	ack, White, e	etc.	
72 hor	ted	15. Decedent's E	lucation	16a. Dece	dent's Usual Occup	ation	(ina	16b. Kind of	Business/Ind	ustry	
ithin han "hee Med	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		kind of work done of DO NOT use retired	i)	9	37 1 *	M 1		
Hygie Thert		9th 17. Father's Name (First, Middle, Last)	Mana	ger	18, Mother's Nam	e (First, Middle	Vendin		ine C	0.
id be lefted of ked o	To Be	George Bake				Mamie B	ell Por	ter	,		
IVICALLY nd 2 shou alth and M 27 is mar r traumat		19a Informant's Name/Relationship (Patricia L. Foste			ng Address (Street) Oakwood R						
es 1 a of Heg		20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □	20b	Place of Dispo cemetery, cre	osition (Name of matory or other plac		Date	20c. Location	- City or To	wn, State	
Pag Iment Iant: I		4 ☐ Donation 5 ☐ Other (Special	y) 1		t Cemeter				sonvil		
permit Depart Import any In		21. Signal 1 Legal Service Lice	nsee		2. Name and Addres						
		23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the de	eath. Do not en	ter the mode of dyin	ig, such as cardiac	or respiratory a	rrest,		Approximat Interval Bet Onset and	te tween
Physician	_	Immediate Cause (Final disease or condition resulting in death)	a. Puncre	as c	ancer				-		ntus
/Medical Examiner		resulting in death)	Due to (or as a cons	equence of):							
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cuted nd ransit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Lind Underlying Cause (Disease or injury that initiated events	C								
ficate be executed physician and the burial-transit	dical Ex	resulting in death) Last	Due to (or as a cons	equence of):							
rtificati	Nedi	IE EEMALE.									
To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending the completely filled in by the funeral director, page 2 should be detached for use as	Physician/Me								Date of delive Month	,	Year
that the ted by detac							ontribute to the cause of death?				
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law re as bee	Completed						24a. Was		o. Were auto	psy findings npletion of c	available cause of
The	Com						perfo 1□ Yes	2 No	death?	2□No	
sician certifi	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 No	Hospital:	□ EB/Outpotio	at all DOA Oth	26. Place of Dea		1/	H	spice	House
a Physer this eral di	H	27. Vancer of Death	28a. Date of Injury	ER/Outpatie			ome 5 Resi 28d. Describe		other (Specify urred	9.4	
tending eath. for: Afte	atio	1 X latural 5 ☐ Pending 2 ☐ Accident investigatio) Injury		Yes 2 □ No					
To the Hospital or Attending F within 24 hours after death. To the Funeral Director: After completely filled in by the funer.	Certification:	3 Suicide 6 Could not b 4 Homicide determined	e 28e. Place of injury - At building, etc. (Spe	t home, farm, st ecify)	reet, factory, office		28f. Location (City or To		mber or Rura	Route Nun	nber,
he Hospi n 24 hour he Funer pletely fill	Medical		nysician: To the best of my k miner: On the basis of exam and manner stated.								s)
To t To t	Σ	29b. Signature and title of certifier	1. 8	20	29c. Licens	e number		29d. Date sig	ned (Month,	Day, Year)	7 2
		Jechen	0-2-		9 9	0000		Sept	Cany	001	16007
1004		30. Name and address of person who	completed cause of death (I	1 (Type	DS Print) AKN AKN AKN AKN AKN AKN AKN AK	#300,	Annen	115,4	102	1401	
	tate	31. Date filed (Month, Day, Year) SEP 2 8 2	' 32 Apriligrar's Sir	anature .			1				
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			1- State of Maryland / Department of Head State of Maryland / Department of Head Certificate of Department of Head State of Maryland / Department /		Reg. N		33209			
ī	Physici		Decedent's Name (First, Middle, Last) Chesley Edward Wooten		Date of Death Month	^y ay Year 200	3. Time of Death 7 8:15 P M			
	/Medic Examin		4a. Facility Name (If not institution, give street and number) Genesis Eldercare Spa Creek Center 4b. City, Town, or Lo			c. County of Deat				
糖	Funeral Director		522–14–6625 11X M 2 F 88 Yrs. Months Days F	Hours Min. 8. C	Date of Birth (Month, Day, Yea Ct. 8, 1	9. Birtl	nplace (State or Foreign Untry) Colorado			
	Maryland 1-f show fied at	tor	Usual Residence of Decedent 10a. State	napolis			10d. Inside City Limits ↑ ↑ ↑ ↑ ↑ ↑ ↑ ↑ ↑ ↑ ↑ ↑ ↑			
36	th with the 23a or 28a ist be noti	Funeral Director	10e. Street and Number 208 Claude Street 21	401	10g. C	Citizen of What Co	untry?			
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	by	11. Marital Status 1 □ Never Married 2 Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 2 Married If Yes, specify Cuban, If Yes, Give Year or Dates: 1942–45 13. Was Decedent of Hisparity If Yes, Specify Cuban, If Yes, Sive Year or Dates: 1942–45	anic Origin? (Specify Mexican, Puerto Rica Specify:	Yes or No- an, etc.)	14. Race - Amer Black, White Specify: Wh	e, etc.			
Maryland 21215-0036	hin 72 ho e. an "natul Medical	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	ing most of working	16b.	Kind of Business/				
121	iled wil Hygien ther th nt, the		Elementary/Secondary (0-12) College (1-4or 5+) 5+ Minister 17. Father's Name (<i>First, Middle, Last</i>)	3. Mother's Name <i>(Fir</i>	rst. Middle. Maide	Relig	ion			
lano	uld be i Aental I rked o	To Be	William A. Wooten	Myrtle (,				
, Mary	and 2 sho salth and N n 27 is ma er trauma		19a. Informant's Name/Relationship (Type. Print) Martha Wooten/wife 19b. Mailing Address (Street and 208 Claude Str	reet Anna	polis, M	aryland	21401			
Baltimore,	Pages 1 ment of He ant: If iten ury or oth		20a. Method of Disposition 1X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) St. Anne's Cemetery		007 An	- '	Maryland			
Balt	permit. Depart Import any Inj		21. Signature of Funeral Source Licensee 22. Name and Address of 147 Duke of		-					
	Physician		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death disease or condition Failure to thrive Approximate Interval Between Onset and Death days							
	/Medical Examiner		Due to (or as a consequence of): Endstage dementia				years			
	ed sit	iner	Sequentially list conditions, if any key at 1 immediate cause. Enter Underlying Cause (Disease or injury that initiated events c			- 9				
68760,	tificate be executed ig physician and as the burial-transit	al Examiner	that initiated events resulting in death) Last C Due to (or as a consequence of):	equence of):						
	rtificate ng phys as the	Medical	0.							
P.O. Box	that the death cert red by the attending detached for use a	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify)		23d. Date of delivery Month Day					
	w requires that the s been signed by the should be detache	by	by	by	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given i	ng cause given in Part I. 23e. Did tobacco use contribute to			
or Vital Records,	law lasb	Completed	<u> </u>		24a. Was an autopsy performed? 1□ Yes 2XX	prior to o	ntopsy findings available completion of cause of			
Vital	Physician: The this certificate I ral director, page	Be	examiner?	6. Place of Death (Cr						
Or	ding Physi h. After this of funeral dire): To	27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at	4 Nursing Home t 28d.	5 Residence . Describe how in		cify)			
Division	Attending r death. ector: After by the funer	atio	2 Accident investigation M 1 Yes	s 2□No						
Divi	al or At s after d il Direct ed in by	Certification:	Suicide 4 Homicide determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		Location (Street City or Town, Sta		ıral Route Number,			
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	edical (29a. Certifier (Check only one) 1X Certifying Physician: To the best of my knowledge, death occurred at the time, 2 Medical Examiner: On the basis of examination and/or investigation, in my opin and manner stated.							
	To the within 2 To the comple	W (29b. Signature and title of certifier D53			oate signed (Mont) September	h, Day, Year) 26, 2007			
	ala.	\mathcal{V}	30. Name and address of person who completed cause of death (item 23a) (Type, Print) Dr. Hung Davis 2001 Medical Parkway Annapol	ic Marula	and 214	01				
	Sta Registr		31. Date filed (Month, Day, Year) SEP 2 7 2007 32. Figistrar's Signature SEP 2 7 2007	PHALY LC	214	V.I				

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			1 - State Registrar	State of Maryland	d / Depa <i>Cei</i>	artment of Ho tificate of D	ealth and N Death	∕lental Hy	gien Reg. No	2007	33210						
	Physici /Medi		1. Decedent's Name (First, Middle, Last	rank Roland WE	ISS			2. Date of De Month Septemb	Da	ay Year 27, 2007	3. Time of Death 7:30 P M						
	Examir Funeral Director		4a. Facility Name (If not institution, give 2816 Bel Pre Road 5. Social Security Number 199-18-5498 18		ast birthday) Yrs.	4b. City, Town, or Silver S If Under 1 Year Months Days		8. Date of Bi	40	Montgome 9. Birth	Pry place (State or Foreign						
	anyland •how		Usual Residence of Decedent 10a. State 10b. County	10c. City	, Town or Lo	cation		I CD . I J	, 1.		10d. Inside City Limits						
	Bs-1 eh	Director	Maryland Montgome	ery	Silve	r Spring					1 □ Yes 2 💢 No						
	death with the Maryland ms 23s or 28s-1 show rivest be notified at	ai Dire	10e. Street and Number 2816 Bel Pre Road			10f. Zip Code	20906			nited Sta							
9036	ours after ral', or ite	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Nividowed 4 Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 Yes 2 No Army 1tYes, Give Year or Dates: 1948	3. 13. V Y	Vas Decedent of His Yes, specify Cuban	spanic Origin? (Sp., Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)	0-	14. Race - Ameri Black, White, Specify: Whi	etc.						
15-(iin 72 h n "natu declical	piete	15. Decedent's Edu (Specify only highest grad	e completed)	16a. Deced (Give life. L	lent's Usual Occupat kind of work done du DO NOT use retired)	tion uring most of work	ring	16b. k	Kind of Business/In	dustry						
212	be filed within 72 hatal Hygiene. Id other than "natuevent, the Madical	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	Manufa	cturer's	Represen	tative		etail Inc	lustry						
land	2 should be filed v n and Mental Hygie 'ie marked other t raumatic event, In	To Be	17. Father's Name (First, Middle, Last) Harry Weiss				18. Mother's Nam Sylvia	e (First, Middle Pollac	, <i>Maidei</i> :K	n Sumame)							
Maryland 21215-0036	ges 1 end 2 should t of Health and Men if item 27 is marks or other traumatic		19a. Informant's Name/Relationship (T) Charles Weiss, So			g Address <i>(Street ar</i> Headwater			er, City	or Town, State, Zip	Code)						
	es 1 en of Heal fitem 2 r other		20a. Method of Disposition ★☐ Burial 2 ☐ Cremation 3 ★☐	20b. Pla		sition (Name of natory or other place		Date		ocation - City or To	own, State						
Baltimore,	t. Pa rtmen rtant: njury		4 Donation 5 Other (Specify) 21. Signature of Funeral Styles License	Har	Jehud	a Cemeter	y 10/0			iladelphi	a, PA						
Ba	Depariment Department of the partment of the p					retrimskyss 4 Carroll					20012						
1	Physician /Medical Examiner		23a. Part1. Enter the disease, or compishock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	ications that caused the death. ne cause on each line. Coronary Arte Due to (or as a consequence)	ery Di		, such as cardiac	or respiratory a	rrest,		Approximate Interval Between Onset and Death 10 YearS						
0	ificate be executed g physicien and as the burial-transit	dicai Examiner	edicai Examiner	niner	niner	niner	niner	miner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, Ciseass or injury that initiated events	Due to (or as a conseque	ence of):						
68760,₹				that initiated events resulting in death) Last	Due to (or as a consequent.	ence of):											
P.O. Box 6	ath certif ettending for use as		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregnan 1 ☐ Live birth 2 ☐ Fetal of 4 ☐ Pregnant at time of decent	death 3 🗌	Ectopic pregnancy Other (specify)				23d. Date of delive Month	ery Day Year						
	w requires thet the de been signed by the s should be detached	Completed by Physician/M	ed by PI	ed by PI	ed by Pr	Part II. Other significant conditions con	ntributing to death but not resul	ting in the un	derlying cause giver	n in Part I.		obacco Yes 2	use contribute to t	ne cause of death?			
Division of Vital Records,	The lar							24a. Was autoj perfo 1 ☐ Yes	psy prmed?	prior to co death?	psy findings available impletion of cause of 2 No						
r Vit	Physician: this certific ral director,	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	lospital:	R/Outpatient	Othor	26. Place of Deat	All The Control		6 □Other (Specif	v)						
sion of	To the Hospitel or Attending Phys within 24 hours atter death. To the Funerel Director: After this completely filled in by the funeral directors.	ation: T	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation		28b. Time of Injury	28c. Injury a Work?		28d. Describe			"						
Divis	tel or Att rs after de el Direct ed in by t	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At hon building, etc. (Specify)	ne, farm, stre	et, factory, office		28f. Location (: City or To		nd Number or Rura 9)	il Route Number,						
	Hospi 24 hou Funer letely fill	edicai	29a. Certifier (Check only one) (Check only one)	sician: To the best of my know ner: On the basis of examination and manner stated.	ledge, death on and/or inv	occurred at the time estigation, in my opin	e, date and place, nion, death occur	and due to the red at the time,	cause(s date and) and manner as s d place, and due to	tated. the cause(s)						
	Within To the comp	W	29b. Signature and title of certifier	3		29c. License				te signed (Month, tember 28							
			30. Name and address of person who co	Jr., M.D., 79			, Takoma	Park,	MD	20912							
Ī	Sta Registr	te	31. Date filed (Month, Day, Year) OCT 0 1 200	32 Pegistrar's Signatu	ire .												

Physician/

Medical Examiner

Funeral

Director

28a-f show

23a or

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

Baltimore, MD 21215-0036

notified at once.

must be

item 27 i

Important: 1

Director

Funeral

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Completed

Be

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 3321 2007 1- For State Certificate of Death Reg. No Decedent's Name (First, Middle,Last) 2. Date of Death 3. Time of Death Month Day October 9, 2007 1231 hrs Alexander Nontez 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number Johns Hopkins Hospital Baltimore 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 6. Sex Foreign Country) Months Days Hours Min 05 1 V M 214-17-1264 2 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 1 Yes 2 No Baltimore 10g. Citizen of What Country 10f. Zip Code 10e. Street and Number USA Avenue *21215* 14. Race - American Indian, Black, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. White, etc Armed Forces? 1 Never Married Yes Yes 2 L No specify: Specify: If Yes. Give Year Divorced Widowed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) Unemployed Unempl 8. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Cynthia Brown Henru 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Nam /Relationship (Type, Print) Baltimore, MD 21215 /mother Hayward unthia 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery Date crematory or other place) Burial 2 Cremation Removal from State 10.16.2007 Windsor Mill, MD Park ling Memorial Donation 5 Other Specify: Vaughn C. Greene Funeral Services 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Ad Baltimore, maryland 21212 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or he Between Onset and failure. List only one cause on each line. Death a. Gunshot Wound of Head Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause: Enter Underlying Cause (Disease or injury that initiated

Physician /Medical xaminer

requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, After

miner within 24 hours after death. To the Funeral Director:

Хa	events resulting in death) Last d.	Due to (or as a consequence or).				
alca	UNPENDED	AMENDED				
nysician/med		9 Olikilowii	23d. Date of delivery Month Day Year			
ompietea by Pr	Part II. Other significant conditions	Solid Balling to Social Section Section 9 and 1	23e. Did tobacco use contribute to the cause of death? 1 Yes 2 ✓ No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings availab prior to completion of cause of death? 1 ✓ Yes 2 No 1 ✓ Yes 2 No			
ڌ	25. Was case referred to medical	26.Place of Death (Check only of	one)			
900		lospital: 1 ✓ Inpatient 2 ER/Outpatient 3 DOA Other 4 Nursing Hor				
HOU:	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	Oct 9, 2007 0000 hrs 1 Yes 2 ✓ No Sub	Describe how injury occurred ject shot			
eruncation	3 Suicide 6 Could not determined	be 28e. Place of Injury - At home, farm, street, factory, office building, etc.	28f. Location (Street and Number or Rural Route Number, C or Town, State) 615 Normal Avenue , Baltimore , MD			
ca Ca		an: To the best of my knowledge, death occurred at the time, date and place, and due to the basis of examination and/or investigation, in my opinion, death occurred at the				

29c. License number O.C.M.E.

111 Penn Street, Baltimore, MD 21201

ORIGINAL

29d. Date signed (Month, Day, Year)

October 10, 2007

DHMH 17 Rev 1/2001 **OCME 2006**

State Registrar 30. Name and address of person who completed cause of death (Item 23a)

lu

Chief Medical Examiner

32. Registrar's Signature

29b. Signature and title of certifier

David Fowler M.D.

31. Date filed (Month, Day, Year)

Phys /Me Exa

Funer Direct

ysician Medical
Medical aminer
within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit.
1/-

	•	State Registrar Certificate of Death						Reg. No. 2007 33212					
icia		1. Decedent's Name (First, Middle, La		2. Date of De Month									
dica		Gladys An	3roc	OKS	ks October				2007	10:22 AM			
nine	r	4a. Facility Name (If not institution, gi				4b. City, Town, or				4c. County of Death			
-wie		4056 St. Augustin				North Po			_		altimor		
al or		,	Sex 7. Age 1 □ M 2 □ X F	e (In yrs. last bir 68	Yrs.	Months Days	If Under Hours	Min.	8. Date of Birth (Month, Day June 16	, Year) , 19	Cou	nplace (State or Foreign intry) yland	
	ŀ	10a. State 10b. County		10c. City, Tow	n or Loc	cation						10d. Inside City Limits	
	Director	Maryland Baltim	ore	North	n Po	int Villa	age			10 011		1 □Yes 💥 No	
į	rai Dir	10e. Street and Number 4056 St. Augustin					222				en of What Cou		
	Funerai	11. Marital Status	12. Was Decedent I Armed Forces?		13. V	Vas Decedent of Hi FYes, specify Cuba	spanic Ori n, Mexica	igin? (Sp n, Puerto	ecify Yes or No- Rican, etc.)	1	 Race - Amer Black, White 		
		1 ☐ Never Married 2 🛣 Married 3 ☐ Widowed 4 ☐ Divorced	1	No.	1	□Yes 21X No	Specify:				Specify: Wh	ite	
	Completed by	15. Decedent's Elementary/Secondary (0-12)	rade completed)		Deced (Give I life. D	ent's Usual Occupa kind of work done of OO NOT use retired	ation during mos)	st of work	ring	16b. Kir	nd of Business/I	ndustry	
	E	12 years	College (1-4or 5)+)	Boo	kkeeper				Acc	ounting	Ī	
	ne C	17. Father's Name (First, Middle, Las	st)				18. Mothe	er's Nam	e (First, Middle,	Maiden 3	Surname)		
[0	George Fickus				İ	Kat	hryr	n Rogers				
	1	19a. Informant's Name/Relationship	(Type. Print)	19b	. Mailin	g Address (Street a	and Numb	er or Rui	al Route Numbe	r, City or	Town, State, Z	ip Code)	
		Carlton Brooks	Husba	nd 40	056	St. Augus	stine	e Lar	ne,Balti	more	, Maryl	and 21222	
		20a. Method of Disposition 1 Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spec		cemete	ry, ciren	sition (Name of natory or other plac prial Garder	e) (Octo 20	ber 20,		eation - City or Tair, MD.		
انه	ŀ	21. Signature of Funeral Service Lice		1	7 22	Name and Addres	s of Facili						
ouce.		hthory	1 con	selle	171	nnelly Fi 10 Solle:	unera rs Po	ıı HC Sint	me oi D Road. D	unda unda	IK,P.A.	21222	
		23a. Parl 1. Enter the disease, or for shock, or heart failure. List of	plications that caused	the death. Do							2.17112.	Approximate Interval Between	
	H	Immediate Cause (Final	y one cause on each iir	1e.		L. D.	1		7:	- 60	-	Onset and Death	
ıl		disease or condition resulting in death)	Due to (or as	onic Obstructive Pulmonary Disease (or as a consequence of):									
r					,								
	ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as	a consequence	of):								
	Examiner	Cause (Disease or injury that initiated events											
ı	EX	resulting in death) Last	Due to (or as	a consequence	of):								
	<u>g</u>		d										
	меспсан	15 F51441 F											
		23b. Was decedent pregnant	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal							2	3d. Date of deli		
	Pnysician/	in the past 12 months? 1 ☐ Yes 2 ☑ No	4□Pregnant at			Ectopic pregnancy Other (specify)					Month	Day Year	
	چّ ا	9 ☐ Unknown	9LIOIIKIIOWII										
		Part II. Other significant conditions	contributing to death be	ut not resulting ir	n the un	iderlying cause give	en in Part I	l.		_	se contribute to	the cause of death?	
1	g								بري 1	es 2]No 3∏Pro	obably 4 □Unknown	
	сотріетей ву				24a. Wa						24b. Were au	topsy findings available completion of cause of	
	E								autop perfoi 1□ Yes	med?	death?		
	De C	25. Was case referred to medical examiner?					26. Place	e of Deat	h (Check only o				
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	Ë [27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Inju (Month, Day	ry 28b.	Time of	28c. Injun Work	/ at </td <td></td> <td>28d. Describe h</td> <td>ow injury</td> <td>occurred /</td> <td></td>		28d. Describe h	ow injury	occurred /		
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27. Manner of Death 1								d Number or Ru	ral Route Number,				
29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place and manner stated. 29b. Signature and title of certifier 29b. Date si													
	M	29b. Signature and title of certifier Wanda	irela m	D		29c. License	0 36	634		29d. Date	e signed (Monti	n, Day, Year) O 7	
)		30. Name and address of person who WANDA WICKS	o completed cause of d	_ /1		1 11 700	1 1	di	te Mar	- D	NI	71701	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Year Month **Physician** AMBLE GEORGE OCTOBER 14 Zout /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE HOSPITAL HARBOR If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 12 M 20 Months Hours Min. West Virginia Days 220-38-9788 66 Director August 17, 1941 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If Item 27 is marked other than "natural", or items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f sh dical Examiner must be notified 1 ☐Yes 2 XNo Director Maryland | Baltimore Dundalk 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21222 USA 1521 Bethlehem Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White þ 3 Widowed 4 Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) if of Health and Mental Hygiene.
If item 27 is marked other than "natu
or other traumatic event, the Medical 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Bethlehem Steel Welder 1 year 12 years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Agnes E. Wolfe George B. Blamble 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1521 Bethlehem Avenue, Dundalk, Maryland 21222 Amelia Blamble 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State October 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Oak Lawn Cemetery Dundalk, MD. 4 ☐ Donation 5 ☐ Other (Specify) 2007 Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, MD. 21 Signature of Funeral Service-Licensee Pat1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) disease **Physician** Stage End Renal 8 months /Medical Due to (or as a consequence of) Examiner response Htrial bibyillation
Due to (or as a consequence of): Atrial Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner To the Hospital or Attending Physician: The law requires that the death certificate be exegated within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a Was an autopsy performed? Yes 2 No 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) ို 1 Yes 2 No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: Injury 1 Natural 5 Pending investigation M 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number RES OOL Octo Bey 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 001 aitewossen

Registrar

DHMH 17 Rev 1/2001

State

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31. Date filed (Month, Day,

32. Registrar signature

BAIN

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#1 perPHYS. G873, 11/16/07 WS

State of Maryland Department of Health and Mental Hygiene 1 - State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Warren Brunette **Physician** SEPTEMBER 28 8:50PM WARREN RURNETTE 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner N/A Baltimore Mercy Hospital If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 6. Sex 1 M 2 ☐ F 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 81 Vrs Director <u>577.44.5801</u> .27.1925 Canada Usual Residence of Decedent with the Maryland 10a, State 10b. Count 10c. City, Town or Location 10d. fnside City Limits rithen "natural", or flema 23a or 28a-f show the Madical Examiner must be notified at 1 Tes 2 No Baltimore **Funeral Director** Md N/A 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Charles St. Apt. 1605 U.S.A. 21201 524 N. filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No þ Specify: White 3 Widowed 4 Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry other then Elementary/Secondary (0-12) College (1-4or 5+) Sales 12 Unknown rmit. Pages 1 and 2 should be filed v portment of Health and Mental Hygie portant: if Item 27 is marked other to Iy njury or other traumatic event, the 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ဥ unknown unknown unknown unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 22 Goucherwoods Ct., Balto, MD 21284

20c. Location - City or Town, State Patrick Dunn/Friend 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 09.28.07 Chesapeake Crem. Beltsville, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Cremation And Funeral Balto M01443 mpc my my Alternatives 8717 Green Pastures Dr. MD Kither 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Centrovandar Physician weks /Medical Examiner typu turion S - uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as nsequence of) Physician/Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit giscan (erone) Due to (or as a conse we nce of): Box 68760. the for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1☐Live birth 2☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 Other (specify) P.O. sate has been signed by the page 2 should be detached 9 Unknown 9 Unknown Part fl. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 Yes 2 No 3 Probably 4 Minknown 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No 21 No 1 ☐ Yes 2 No funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Appatient Certification: To 2 ER/Outpatient 3 DOA 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A investigation the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier completely (Check only one) To the 29b. Signature and title of certific 29d. Date signed (Month, Day, Year) 29c. License number Than Poin, MD, FACE D 57088 OCTOBER b 30. Name and address of persop who completed cause of death (ftem 23a) (Type, Print) Plan Botim, mi) 301 17 32: Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

		1- State of Mar State of Mar Registrar	yland / Department of Health and N Certificate of Death	Mental Hygiene 007 33215
Physi		Decedent's Name (First, Middle, Last) LEONA N. BALLING	1	2. Date of Death Month Day Year 4 5 5 A M
/Med Exam	dical niner	4a. Facility Name (If not institution, give street and number) Beh A. B. Heal th	Rehab Be Rehab	4c. County of Death And Fund
Funera Directo		5. Social Security Number 6. Sex 7. Age (215~50~8904 1 M 200 F 92	2 Yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) May 2.1915 Maryland
yiand sow		Usual Residence of Decedent 10a, State 10b. County 1	Oc. City, Town or Location	10d. Inside City Limits
he Mar 28a-fat	Director	Maryland Harford	Belair	1 □Yes ¾CXNo
3a or	ā	900 Featherstone Ct.	10f. Zip Code 21014	10g. Citizen of What Country?
death	Funerail	11. Marital Status 12. Was Decedent Eve Armed Forces?		
in E.; IN all year LO ZICE 13-00.30 s. 1 and 2 should be filed within 72 hours after death with the Maryland if the sith and Mental Hygiene. If the marked other then "nature!; or Items 28a or 28a-f show other traumatic event, the Medical Examinar must be notified at	۾	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 [X]No If Yes, Give Year or Dates:	1 ☐ Yes 2 ☑ No Specify:	specify: White
hin 72 h	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	16a. Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired)	ing 16b. Kind of Business/Industry
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d be fill antal H ced out	Be	17. Father's Name (First, Middle, Last)		e (First, Middle, Maiden Surname)
shoul and Me	J.	Peter Bauernfiend 19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rura	HOTN al Route Number, City or Town, State, Zip Code)
and 2 and 2 ealth a m 27 th		Diane J. Buchanan (Daughter		- CO()-1:
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nit. Pa artmer ortant injury	4	4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee	Parkwood Cemetery 10=1 22. Name and Address of Facility	5-2007 Baltimore, Md.
permit. Departition of the permit of the per	Suc	1 6. J. Lassahn	Lassahn Funeral He	ome 7401 Belair Rd. Baltimore, Md. 21236
Pnysiciai /Medica Examine	al	23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause or each line. Immediate Cause (Final disease or condition resulting in death) a	moria	
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or Attend fler death director: /	Certification;	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury building, etc. (M 1 Yes 2 No - At home, farm, street, factory, office (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)
To the Hospital or Attendia within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical Ce	(Check only 2 Medical Examiner: On the basis of ex	my knowledge, death occurred at the time, date and place, camination and/or investigation, in my opinion, death occurr	and due to the cause(s) and manner as stated. red at the time, date and place, and due to the cause(s)
Fo the within 2 Fo the	Mec	29b. Signature and filled pertified	29c. License number	29d. Date signed (Month, Day, Year)
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3		a e and ad ress of person who completed cause of deal votes of the Do FA	h (Item 23a) (Type, Print) (1308 Bushis Content	Vas Edgewood MD 21040
S Regis	State	31. Date filed (Month, Day, Year) 32. Registrar's	Signature	/ /

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ione Lamont B		1- For State Certificate of Death	and Mental Hy		.No. 200	73321
Physicia Nedical Exami	an/	1. Decedent's Name (First, Middle,Last)		Date of Death Month October 14		3. Time of Death 2034 hrs
			n, or Location of Death		4c. County of Death	
Funeral Director		1X M 2 F 33 Yrs.	Year If Under 24Hrs. Days Hours Min.		(MM/DD/YYYY) 9. Birth Foreign Coul	place (State or NEW YORK
Jaryland 28a-f show any 1 at once.	or	Usual Residence of Decedent 10a. State 10b. County MD N/A BALTIMORE CI	ITY			10d. Inside City Limits
th the Maryland 23a or 28a-f sho notified at once	I Director		de 21215	109	g. Citizen of What Count USA	ry?
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11215-0036 d be filed within 72 hours fental Hygiene. tarked other than "natur event, the Medical Exami	Completed b		g life. DO NOT use retire	d)	16b. Kind of Business/In OWINGS RI APARTMEN	UN
21215-0 Muld be filed w Mental Hygie marked other c event, the M	Be	LOUIS MC LENDON	18.Mother's Name (I	INE PI	ERCE	
MD 21 Id 2 should lith and Me in 27 is ma	То	MICHELLE D. SKINNER/SISTER 4007 W. F	ROGERS AVE	E., BA	LTIMORE, I	MD 21215
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than injury or other traumantic event, the Medical		20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other Specify: 20b. Place of Disposition (Name of crematory of other place) ARBUTUS MEM.	PARK 10/2	20/07	20c. Location - City or T	E CO., MD
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Physician /Medical `xaminer	1 1	2 PM Enter the Isease, or complications that caused the Island. Do not enter the mode of dy failure. List only one cause on each line. Illurediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):		respiratory arres	st, shock, or heart	Approximate Interval Between Onset and Death
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ox 68760, eath certificate be executed attending physician and for use as the burial - transit	ician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death	3 Ectopic pregnan	су	23d. Date of delivery Month Di	ay Year
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Division of Vital Records, P.O. Box 68760, Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. Funeral Director: After this certificate has been signed by the attending physician and attended in by the funeral director, page 2 should be detached for use as the burial - transit	ပ္	1 Ves 2 No Inpatient 2 ER/Outpatient 3 DOA	. Injury at Work?		Residence 6 Other:	
Divisior To the Hospital or Attend within 24 hours after death. To the Funeral Director: completely filled in by the	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined (Specify) Front yard of residence		or Town, Sta	reet and Number or Rur ate) Avenue, Baltimore, N	
To the Hospi within 24 hou To the Funer completely fi	Medical C				1 1	
Esta	Me		cense number		29d. Date signed (Mon October 15, 2007	
H		30. Name and address of person who completed cause of death (Item 23a)	et, Baltimore, MD 2	1201		
St Regist	ate rar					
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DHMH 17 Rev 1/2001 OCME 2006

Division or Vital Records, P.O. Box 68760,

Physician /Medical 4a. Facility Name (If not institution, give street and number) Examiner Northwest Hospital Center Social Security Number Funeral Director 218-12-2492 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show 10a. State must be notifled Director MD 10e. Street and Number 4407 Chapeldale Road by Funeral 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 3 Widowed 4 Divorced Completed Elementary/Secondary (0-12) 17. Father's Name (First, Middle, Last) Be Joseph Blair ပ 19a. Informant's Name/Relationship (Type. Print) Catherine C. Blair 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Signature of Funeral Service/Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed Physician/Medical IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No autopsy performed? res 2 X No 1□ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2[**X**No 1 Inpatient ٩ 1 Yes 2 ER/Outpatient 3□ DOA 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred Certification: Injury (Month, Day Year) 1 Natural 5 ☐ Pending investigation M 1 ☐ Yes 2 ☐ No 2 ☐ Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier Medical and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signaty 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Structure (Tu) (By 5401 Old Count Rond (CANDAlls+ 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For
 State
 Registrate Certificate of Death I. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Booker October 11, Nancy Margaret 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 6301 Avalon Drive Bethesda Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 1□M 27 F Months Days Hours Min. 395-38-3665 Director 66 May 11, 1941 Wisconsin Usual Residence of Decedent 10c. City. Town or Location 10a. State 10b. County 10d. Inside City Limits Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Directo Maryland | Montgomery Bethesda 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6301 Avalon Drive 20816 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 1 ☐ Never Married 2X Married ☐ Yes 2 X No Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) 5+ Clinical Social Worker Non Profit Organization permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked other any Injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Edward E. Mann ပ Eleanor A. Hoffmann 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thomas Hoy Booker / Husband 6301 Avalon Drive, Bethesda, Maryland 20816 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State October 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Montgomery Crematorium, Inc 14, 2007 Bethesda, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses . 22. Name and Address of Facility. Robert A. Pumphrey Funeral Home/Bethesda—Chevy Chase, Inc. Musalette Barri M01305 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, in heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Mescenteric Panniculitis **Physician** Weeks /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter or denying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner the burial-transi and Due to (or as a consequence of): Box 68760 attending physician for use as the buria The law requires that the death certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 1 Live hirth 2 Fetal death in the past 12 months? 1 ☐ Yes 2 🔯 No Month Day Year 5 ☐ Other (specify) 4☐Pregnant at time of death P.O. detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, à Myelodysplastic Syndrome 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has perform 1□ Yes 2 2 No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 🔀 Residence 6 Other (Specify) Hospital: 1 X Yes 2 No 10 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t Certification: Injury 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident death Director: 6 ☐ Could not be 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D42452 October 12, 2007 9 30. Name and address of person into completed cause of death (Item 23a) (Type, Print) Chitra Rajagopal, M.D. 18111 Prince Philip Drive, #327, Olney, Maryland 20832 31. Date filed (Month, Day, Year) Registrar's Signature 7 2007 OCTI Registra

DHMH 17 Rev 1/2001

Thomas Edward Benzing State of Maryland / Department of Health and Mental Hygiene 33219 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) Physician/ 2. Date of Death Month Day October 15, 2007 0429 hrs Medical Examiner THOMAS EDWARD BENZING 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 14 Naylor Blue Court Port Deposit 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or **Funeral** Hours Months Director Country) MD 218-48-4115 12/28/1946 1 X M 2 F 60 Yrs Usual Residence of Decedent 10d. Inside City Limits any 10a. State 10b. County 10c. City. Town or Location 1 Yes 2 XNo MD CECIL PORT DEPOSIT hours after death with the Maryland Director or 28a-f fied at o 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 14 NAYLOR BLUE COURT 21904 U.S.A. Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 XMarried 1 X Yes 4 Divorced If Yes, Give Year 1966-69 Widowed Yes 2 X No specify: WHITE ģ 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation (Give kind of work done 16b, Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Pages I and 2 should be filed within 72 nent of Health and Mental Hygiene. is marked other than " NORTHROP Baltimore, MD 21215-0036 ADMINISTRATOR GRUMMAN 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be **JAMES** BENZING MARY C. **JOHNSON** Α. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) KATHLEEN BENZING/ If item 27 NAYLOR BLUE COURT, PORT DEPOSIT, MD. 21904 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State permit. Page Department of Important: injury or oth SACRED HEART OF JE\$US 10/19/07 BALTIMORE, MD. Donation 5 Other Specify 21. Signature of Funeral Service Licenses 22 Nemeric Address of EETLER INC. FUNERAL HOME 1901 EASTERN AVENUE, BALTIMORE, MD 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interva Physician Between Onset and /Medical Death a. Hypertensive atherosclerotic cardiovascular disease Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit The law requires that the death certificate be executed Physician/Medical attending physician a X UNPENDED #251,57, perME, g873, 11/6/07 TT O. Box 68760 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? Live birth 3 Ectopic pregnancy Year Fetal death Day Pregnant at time of death Other (Specify) 5 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Records, P. Completed 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of has 2 sl performed' death? certificate ✓ Yes 2 No 1 🗸 Yes the Hospital or Attending Physician: 25. Was case referred to medical 26.Place of Death (Check only one) Division of Vital Be Hospital: 1 Other₄ examiner? DOA Inpatient 2 Nursing Home 5 Residence 6 ✔ Other: Scene ER/Outpatient 3 ٩ 1 🗸 Yes After 27. Manner of Death 28a. Date of Injury (Month, Dey, Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Injury Certification: n 24 hours after death.
re Funeral Director: A
letely filled in by the fu 1 X Natural l Director: 5 Pending 1 Yes 2 No 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Could not be Suicide or Town, State) determined Homicide 29a. Certifier (Check only Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical To the 1 2 📝 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. October 15, 2007 RUD ashe 30. Name and address of person who completed muse of death (Item 23a) Tasha Greenberg MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year) **0CT 1** 6 2007 . Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 00 2. Date of Death Decedent's Name (First, Middle, Last) Day 13 Month **Physician** 5:15a. Campbell 10 2007 Wynn Naomi Jean /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Blue Point Nursing | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, O9 18 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) ^{Yea}r) 35 **Funeral** 1 □ M 2 🔀 F 243-32-9243 NC Director 72 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a State 10h. County show "naturai", or items 23a or 28a-f sho dical Examiner must be notified at Y☐Yes 2☐No Director Baltimore MD NA 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21215 U.S.A. 4102 Fordleigh Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ② No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 🙀 ☐ No Specify: Specify: Black þ 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the M. Elementary/Secondary (0-12) College (1-4or 5+) llth gradé Dietary Work Hospital 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Hattie Hux Dallas Wynn 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 4102 Fordleigh Road, Baltimore, Md 21215 Larry Campbell-Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Durial 2 ☐ Cremation 3 ☐ Removal from State ☐ Donation 5 ☐ Other (Specify) Garrison Forest Vet 10/19/07 Owings Mills, Md 22. Name and Address of Facility
March F/H West
4300 Wabash Ave, Baltimore, Md 21. Signature of Funeral Service Licensee 21215 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fallure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ALZHEIMERS **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate causs. Enter uncertying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed physician and the burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical attending ph IF FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal de 23d. Date of delivery 23b. Was decedent pregna 3 Ectopic pregnancy 2 Fetal death in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day 4□Pregnant at time of death 5 Other (specify) has been signed by the e 2 should be detached 9 I Inknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 4 Dunknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? certificate has rector, page 2 1□ Yes 2 25. Was case referre to medical director, 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient Medical Certification: To 1 ☐ Yes 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation s after death.

I Director: A
od in by the fu 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours aff

To the Funeral D

completely filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar

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2835,

32. Hegistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

AKHAN

28551

SUITE 203,

Registrar DHMH 17 Rev 1/2001

State

29b. Signature and title of certified

31. Date filed (Month, Day, Year)

OCT 1

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

7 2007

32. Registrar's Signature

Date of the said

the

NEIL C. EVANS, M.D., VAMC, 50 IRVING STREET NW, WASHINGTON, DC 20422/688

Buch

29c. License number MD# 57340 29d. Date signed (Month, Day, Year)

OCTOBER 11, 2007

State of Maryland / Department of Health and Mental Hygiene 33222 Certificate of Death Reg. No 1- For State 2. Date of Death Registrar Month Day October 10, 2007 1. Decedent's Name (First, Middle,Last) 1325 hrs Physician/ ¬I Examiner 4c. County of Death Joseph 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number Baltimore 4627 Northwood Drive 9. Birthplace (State or 8. Date of Birth (MM/DD/YYYY) If Under 1 Year If Under 24Hrs. 7. Age (In yrs. last birthday) 6. Sex oreign 5. Social Security Number **Funeral** Davs Hours Min Months Country) 6 12 42 Director 1 X M 214-40-6828 Usual Residence of Deceden 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 1 Yes 2 No 23a or 28a-f show notified at once. Baltimore N/A with the Maryland 10g. Citizen of What Country Directo 10f. Zip Code 10e. Street and Number 21239 4627 Northwood Drive 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. Funeral White, etc. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? Married death , Never Married 2 1 X Yes Black Specify: Yes 2 X No specify: 9 If Yes, Give Year 4 Divorced Widowed hours after 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done "natural" 3 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) nit. Pages 1 and 2 should be filed within 72 hour rement of Health and Mental Hygiene. Completed College (1-4 or 5+) Flementary/Secondary (0-12) Baltimore City Board of Education N/A 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Wriaht Ethel Be Cross Benjamin (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 4627 Northwood Dr. more, MD 21239 20c. Location - City or Town, State venue Baltimore, MD Theresa Cross-wife 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition crematory or other place) Baltimore, 1 X Burial 2 Cremation 3 Removal from State 10/19/2007 Owings Mills MD Garrison Forest VA Important: injury or otl Donation 5 Other Specify 22. Name and Address of Facility MARCH FUNERAL HOME-EAST 21. Signature of Funeral Service Licensee 21202 Baltimore, MD 1101 E. North Avenue 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart) am Approximate Interval Between Onset and Physician Death failure. List only one cause on each line. a. Smoke Inhalation and Thermal Injuries **Medical** Immediate Cause (Final disease xamine or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examiner cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit 19b per fh g872 10-19-07 vt Physician/Medical X AMENDED UNPENDED ending physician use as the burial -23d Date of delivery The law requires that the death certificate be Box 68760, 23c. If yes, outcome of pregnancy IF FEMALE: Month Year 3 Ectopic pregnancy 23b. Was decedent pregnant in the Fetal death Live birth past 12 months? Pregnant at time of death Other (Specify) 5 signed by the atte 1 Yes 2 No 9 Unknown a Unknown 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. Part II. Other significant conditions Ö 1 ✓ Yes 2 No 3 Probably 4 Unknown þ Atherosclerotic cardiovascular disease Δ. 24b. Were autopsy findings available 24a. Was an Completed Division of Vital Records, prior to completion of cause of autopsy death? performed? has 1 🗸 Yes Yes 2 certificate 26. Place of Death (Check only one) 25. Was case referred to medical Hospital or Attending Physician: 24 hours after death. Residence 6 V Other: Scene Be Other₄ Nursing Home 5 Hospital: ER/Outpatient 3 Inpatient this 1 V Yes 28d. Describe how injury occurred ٩ 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) Oct 10, 2007 28b. Time of Injury 27. Manner of Death Victim of house fire After 1205 hrs Certification: Yes 2 V No Natural 5 Pending by the 28f. Location (Street and Number or Rural Route Number, City Director: 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State) 4627 Northwood Drive, Baltimore , MD Could not be 3 Suicide (Specify) Townhouse / Rowhouse determined within 24 hours a To the Funeral I 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 1 2 W Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier October 11, 2007 O.C.M.E. mi 30. Name and address of person who completed cause of death (Item 23a) 5+1 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Ling Li, MD 31. Date filed (Month Car 32. Registrar's Signature 200 State Registra

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** 15: Mary Ellen October 10 207 Cozart /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Union Memorial Hospital Baltimore If Under 1 Year Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months Days Hours 1 □ M 245XF Director 238-70-5290 64 12 1942 11 N.C. Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a State 28a-f show at 1xxYes 2 □ No ns 23a or 28a-f sh must be notified MD N/A Baltim ore Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 2405 St. Stephens Ct. 21216 USA Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene.
whit if Item 27 is marked other than "natural", or items 23, and: If item thaumatic event, the Medical Examiner must ary or other traumatic event, the Medical Examiner must by Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. Yes 2 No f Yes, Give 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify. 3 ☐ Widowed 4 ☑ Divorced Black Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12th Citywide Bus Co. Attendant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Otis Cozart Etheline ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bridget Mazyck-daughter 9 Yardley Ct. Baltimore, MD 21244 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a, Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department o Important: If any Injury or Greenmount Crematory 10/17/2007 Baltimore MD 22. Name and Address of Facility 21. Signature of Funeral Service Licensee MARCH FUNERAL HOME-EAST 1101 E. North Avenue Baltimore, MD 21202 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Beosis **Physician** week disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner ostridium difficile infection Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Squamous Cell Cancer of Rectum the Hospital or Attending Physician: The law requires that the death certificate be executed Kecurrent Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical the attending ph 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Seizure disorder 2 No 3 Probably 4 DOnknown 1 Tyes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed certificate Yes 2 □ No Be (25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Mann of Death 28c. Injury at Work? 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death | Director: / d in by the f 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours aft

To the Funeral Di

completely filled in 1 Feertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier AT2438946 October, 10, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) rson who completed cause of death (Item 23a) (Type, Print)

KHATKAR M D. UNION MEMORIAL HOSPITAL 201 EAST UNIVERSITY PARKWAY
BALTIMORE, MARYLAND SON \$2. Registrar's Signature 31. Date filed (Month, Day, Year) State 2007 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		For State Registrar				rtificate of I		-	Reg. No. 20	07	33225
Physic /Med		Decedent's Name (First, Middle, PeiLin Wu Chen	Last)					2. Date of De Month Octok	Day Day Der 11,	Year 2007	3. Time of Death 6:25 AMM
Exam		4a. Facility Name (If not institution,	give street and nu	mber)		4b. City, Town, or	r Location of Dea		4c. County		
		Casey House					Rockvi		Mont	tgomer	· y
Funera Directo		5. Social Security Number 411–19–8848	5. Sex 1 □ M 2 🗷 F	7. Age (In yrs. 7]		If Under 1 Year Months Days	If Under 24 Hrs Hours Min	. (Month, Da	th y, Year) 7/1936	9. Birthpla Counti Tai	ace (State or Foreign ry) wan
pu ,		Usual Residence of Decedent		100 0	ity, Town or Lo	cation				140	ad Jacido City Limite
aryla shov	=	10a. State 10b. County								10	ld. Inside City Limits 1 Yes 2 No
the M 28a-f otifie	Funeral Director	MD Monte	gomery	R	lockvil	10f. Zip Code			10g. Citizen of V	Mhat Count	
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leath ns 23 mus	era	11. Marital Status	12. Was Dec	edent Ever in U	J.S. 13. 1			Specify Yes or No		e - America	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at anneas.	by Fun	1 ☐ Never Married 2 ☑ Marrie 3 ☐ Widowed 4 ☐ Divorced	Armed Fo 1 ☐ Yes If Yes, Gi Year or D	2 🔀 No ve		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	an, Mexican, Puè Specify:	rto Rićan, etc.)	Specify	ck, White, e	
2 hou attura	ted	15. Decedent's	Education		16a. Dece	dent's Usual Occup	ation	1	16b. Kind of Bu	usiness/Indi	ustry
e. Medi	Completed	(Specify only highest Elementary/Secondary (0-12)	College (1-4or 5+)	life.	kind of work done on NOT use retired	during most of wo d)	orking	Own H	ome	
d will yield	lo S	12			Home	emaker					
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Men arke	ြို	Chao Wan Wu					Wany				
2 sh 2 sh 1 and 1s m		19a. Informant's Name/Relationshi Shen Show Chen/				ng Address (Street					Code)
and lealth			nusband	lanh		Longhor					Ot-t-
permit. Pages 1 and : Department of Health Important: If item 27 any injury or other tr		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 4 ☐ Donation 5 ☐ Other (Spi		State		esition (Name of matory or other place eake Crema	1	Oct 16 2007	20c. Location -	•	wn, State Maryland
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		23a. Part1. Enter the disease, or of shock, or heart failure. List o	omplications that	caused the dea	th. Do not ent	er the mode of dyin	ng, such as cardia	ac or respiratory a	rrest,		Approximate Interval Between
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tending Physician: The law requires that the death certical. Seath. Story After this certificate has been signed by the attendir The funeral director, page 2 should be detached for use	Physician/	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No	1 ☐Live	tcome pf pregn birth 2 ☐ Fet nant at time of a lown	al death 3	Ectopic pregnancy Other (specify)	y 			te of deliver onth [ry Day Year
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ysic	0	examiner? 1 ☐ Yes 2 ☑ No	Hospital:	Inpatient 2	ER/Outpatier	nt 3 DOA Oth	er: 4 \sum Nursing	Home 5 ☐ Resi	dence 6 YOth	er (Specify	HOSDICE IPU
neral	Ë	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date	of Injury oth, Day Year)	28b. Time o Injury	f 28c. Injur Wor	y at k?	28d. Describe	how injury occur	red	
endir ath. or: Af	atic	2 ☐ Accident investiga	ition	,,,	, , ,		Yes 2 ☐ No				
s after de al Direct	Certification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	28e. Place	e of injury - At h ling, etc. (Spec	nome, farm, str ify)	reet, factory, office		28f. Location (City or To	Street and Numb wn, State)	er or Rural	Route Number,
To the Hospital or Attending Physician: The law requires that the death cell within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use	Medical (29a. Certifier 1 ☐ Certifying (Check only one) 2 ☐ Medical E	xaminer: On the I	e best of my kn basis of examin nner stated.	owledge, deat ation and/or in	h occurred at the til vestigation, in my c	me, date and place opinion, death occ	ce, and due to the curred at the time,	cause(s) and made and place,	anner as sta and due to	ated. the cause(s)
To th withir To th	Me	29b. Signature and title of certifier	/	10	1	29c. Licens	e number		29d. Date signe	d (Month, E	Day, Year)
)		Menione	Wrol	uler 5	K'ui	1 1)(()(04 (D)	15	10	12/	77
/		30. Name and address of person w	ho completed cau	se of death (Ite	m 23a) (Type,	Print)	/~ + 1 .			,	1

State Registrar DHMH 17 Rev 1/2001

Genevieve Wroblewski 31. Date filed (Month, Day, Year)

Ki mo 1355 Piccoard Dr Rockville Mo 20850

Please Ty	ype or	Print	in Black	Indelible Ink.	Ensure Ali	Copies A	Are Legible
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		1	For State Of M6 State Registrar	aryland / Depa <i>Cer</i>	tificate of L			ene a. No 2007	33226
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**	/Medic	al .	CHARLES RIVERS CARROL 4a. Facility Name (If not institution, give street and number)	L,JR.	4b. City, Town, or		October 13	4c. County of Dea	
	Examin	er	SINAL HOSPITAL OF BALTIM	nore	BACTI				
	Funeral Director		115-03-5675 1XDM 2□F	e (In yrs. last birthday) 88 Yrs.	If Under 1 Year Months Days	if Under 24 Hrs. Hours Min.	8. Date of Birth Month, Day, 1 / 1 5 / 1 9	Year) C	thplace (State or Foreign ountry)
	ryland how lat		Usual Residence of Decedent 10a. State 10b. County MD	10c. City, Town or Lo					10d. Inside City Limits 1
	he Ma 28a-f s otifiec	ecto	10e. Street and Number	DALITHON	10f. Zip Code		10	g. Citizen of What C	
	th with t 23a or 2 ust be n	al Dir	202 WYNDHURST AVENUE			21210		U;	SA
036	ges 1 and 2 should be filed within 72 hours after death with the Maryland tr of Health and Mental Hygiene. If Item 27 Is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	by Fur	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Armed Forces? I ☑ Yes, Give Year or Dates:	No	Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 🛣 No	spanic Origin? (Spe n, Mexican, Puerto I Specify:	cify Yes or No- Rican, etc.)	14. Race - Am Black, Whi Specify: W	te, etc.
21215-0036	"natur	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give	dent's Usual Occup kind of work done o DO NOT use retired	luring most of workii	ng 1	6b. Kind of Business	s/Industry
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	al Hygi I other vent, ti	BeC	17. Father's Name (First, Middle, Last)			18. Mother's Name			
ylaı	should be ind Mental marked o	2	CHARLES R. CARROLL	40/ 14/7		DOROTH			Zin Codo)
Maryland	ınd 2 sh alth and 27 Is m er traum		19a. Informant's Name/Relationship (Type. Print) ANN KLASSEN daught					City or Town, State,	
Baltimore,	Pages 1 and 3 nent of Health ant: If Item 27 ary or other tra		20a. Method of Disposition 1 Burial 2 ACremation 3 Removal from State 4 Donation 5 Other (Specify)	20b. Place of Dispo	osition (Name of matory or other place	e)		0c. Location - City o	
Baltir	permit. Page Department of Important: If any Injury or once.		21. Signature of Fun Service License					JENKINS ON, MD	
			23a. Part1. Enter the disease, or complications that cause shock, or heart failure. List only one cause on each I						Approximate Interval Between
(CI)	Physician		Immediate Cause (Final disease or condition	IRATORY F					Onset and Death
	/Medical Examiner		resulting in death) Due to (or as	a consequence of):	lie energi				
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or Vital Records,		Completed	THROMBO CYTORENIA				24a. Was ar autops perforn 1□ Yes 2	y prior to ned? death?	autopsy findings available o completion of cause of ? es 2 \(\text{No} \)
/ita	Physician: The this certificate ral director, pag	Be (25. Was case referred to medical examiner?		nt 3 DOA Oth	26. Place of Deatl			
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Division	는 A C	Certification:	3 Suicide 6 Could not be 28e. Place of in	jury - At home, farm, st tc. <i>(Specify)</i>	reet, factory, office		28f. Location (Sti City or Town	reet and Number or in State)	Rural Route Number,
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7	6+1		30. Name and address of person who completed cause of Luis Ross-CACELON SINH HOSPI			W. BELVEDER	E AVE. B	ALTIMORE M	00 21215
	Sta Regist		31. Date filed (Month, Day, Year) 32. Regis	trar's Signature	W)				

4b. City, Town, or Location of Death

Towson

Day

16, 2007

4c. County of Death

Baltimore

9:37AM

Month

October

Physician /Medical Examiner

Ruth

Gilchrist Center for Hospice Care

Jeannette

4a. Facility Name (If not institution, give street and number)

Cadwallader

Funeral Director show

r 28a-f show notified at "natural", or Items 23a or Pages 1 and 2 should be filed within 72 hours after death Medical Il Hygiene. the of the state of th other or other train permit. Page Department or Important: If any Injury or once,

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

burial-tran physician the as attending p ed by the a Jas page certificate Hospital or Attending Physician: funeral director. this After death. ours after death.

neral Director; A
filled in by the fu within 24 hours af

To the Funeral D

completely filled i

The law requires that the death certificate be executed

Box 68760.

P.O.

Records.

Division or Vital

the

If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Days Months Hours 1 □ M 2 □ F 207-40-8966 Oct. 17, 1949 PA Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 No Director MD Baltimore **Glyndon** 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21071 USA Funeral 207 Central Ave 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: Specify þ 3 ☐ Widowed 4 X Divorced Year or Dates White Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Balt. County Schools Teacher 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဥ Muriel Morrow Andrew Liberda 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 207 Central Ave., Glyndon, MD 21071 Jennifer L. Diaz Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Carroll Cremation 10/17/07 Hampstead, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 11824 Reisterstown Road Eline Funeral Home Reisterstown, MD 21136 Ems en 23a. art1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest nock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) OUAriAN c Ancek ean Due to or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Usease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4⊡Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To pice 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and titlerof certifier

State

Registrar

N.

"Charles St. Balto md 2120x

death (Item 23a) (Type, Print)

6701

32. Registrar's Signature

and address of person who completed cau-

Year)

7 2007

31. Date filed (Month, Day,

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State of Maryland / Department of Health and Mental Hygiene 2007 33228 1- For State Certificate of Death Reg. No Registrar 2. Date of Death Decedent's Name (First, Middle,Last) 1310 hrs October 10, 2007 Medical Examiner Dennis Alan Connery 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Johns Hopkins Bayview Medical Center **Baltimore** 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign If Under 1 Year | If Under 24Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Country) Months Days Hours July 12, 1946 PA Director 61 218-48-3462 1 X M 2 F Yrs Usual Residence of Deceden 10d. Inside City Limits 10a, State 10b. County 10c. City, Town or Location 1 Yes 2 No MD Essex 28a-f shov Baltimore notified at once. Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 2256 Monocacy Rd. 14 Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. Funeral 11. Marital Status White, etc. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 1 Never Married 2 X Married 2 1 X Yes Specify: White 1 Yes 2 X No specify: If Yes, Give Year Divorced 3 Widowed 1964-68 the Medical Examiner þ 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Pages I and 2 should be filed within 72 hours nent of Heath and Mental Hygiene. ant: If item 27 is marked other than "natur: or other traumatic event, the <u>Medical Exami</u> Completed Elementary/Secondary (0-12) College (1-4 or 5+ Baltimore, MD 21215-0036 Fire Protection Pipe Fitter 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ester Flora Webb Jack Connerv 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) ပ MD22<u>56 Monocacy Rd.</u> Essex. Paula Connery/wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition crematory or other place) Removal from State Burial 2 X Cremation 3 10/17/07 Beltsville, MD Chesapeake Crematory Donation 5 Other Specify 22. Name and Address of Facility Going Home Cremation Service P.O. Box 784 21. Signature of Funeral Service Licens MO1251 Beverly I. Heckrotte, P.A. Cl.
The disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock Part I Ente **Physician** Between Onset and failure. List only one cause on each line /Micdical Pulmonary hypertension complicated by narcotic use Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause Examine (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): pue Physician/Medical X UNPENDED AMENDED. #23a,PII,27,perME,g874, 12/13/07_TI attending physician for use as the burial -To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physici 23d. Date of delivery Box 68760 23c. If yes, outcome of pregnancy IE EEMALE: Day Year Month 23b. Was decedent pregnant in the 3 Ectopic pregnancy Live birth Fetal death signed by the attending be detached for use as t past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. P.O. Yes 2 No 3 Probably 4 ✔ Unknown ģ Cirrhosis, chronic alcoholism, hepatitis C Completed 24b. Were autopsy findings available of Vital Records, has been s 24a. Was an prior to completion of cause of autopsy performed? death? 1 🗸 Yes ✓ Yes 2 No 26.Place of Death (Check only one) 25. Was case referred to medical Other: Hospital: 1 ✓ Inpatient 2 Nursing Home 5 Residence 6 ER/Outpatient 3 1 🗸 Yes 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27 Manner of Death Certification: 1 X Natural Yes 2 No Division 5 Pending Director: 2 Accident 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc filled in by 3 or Town, State) 6 Could not be Suicide determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical one) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie October 11, 2007 O.C.M.E. well 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Laron Locke MD. Assistant Medical Examiner 32 Registrar's Signature 31. Date filed (Month, Day, Year OCT 1 7 State 2007 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death October 13, 2007 Mary Ann Carlson 1:50 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 14810 Kelly Farm Drive Darnestown Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 1 □ M 2 🔀 F 245-28-8918 80 June 21, 1927 North Carolina Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 □Yes 2KNo Maryland Montgomery Darnestown 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 14810 Kelly Farm Drive 20874 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Black, White, etc. 11. Marital Status 1 ☐ Yes 2 📆 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☒ No Specify White Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charlie Pace Marian Potts 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles Eric Carlson / Husband 14810 Kelly Farm Drive, Darnestown, Maryland 20874 Darmees town Presbyterian October Church Cemetery 20c. Location - City or Town, State 17, 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 2007 4 ☐ Donation 5 ☐ Other (Specify) Church Cemetery Darnestown, Maryland 21. Signature of Funeral Service 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Rockville, Inc., 300 West Montgomery Avenue, Rockville, Maryland 20850-2805 Rockville, Rockville, M01473 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Acute Leukemia 1 Month Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🔀 No Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9□Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Cirrhosis of Liver, Macular Degeneration 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hypothyroidism autopsy performed 1 ☐ Yes 2 X No 2 No Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 🖾 Residence 6 ☐ Other (Specify) 28a. Date of Injury 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 🖸 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Examiner Box 68760 Division or Vital Records, P.O.

The law requires that the death certificate be executed physician an s the burial-tr attending pl signed by the a d be detached f certificate has trector, page 2 s or Attending Physiclan; director this æ After death. after death.

Director: / To the Hospital o within 24 hours aff To the Funeral Di completely filled in

Physician

/Medical

Examiner

Funeral

Director

28a-f show ns 23a or 28a-f shov must be notified at

Items 23a

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Ith and Mental Hygiene. 27 is marked other than "r r traumatic event, the Med

permit. Pages 1 and 2 s Department of Health an Important: If item 27 is any Injury or other trau once.

Physician

/Medical

Examiner

Physician/Medical

Completed by

Be

Certification: To

Medical

Examiner

Medical

Directo

Funeral

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Completed

the Maryland

with

death

Pages 1 and 2 should be filed within 72 hours after

Baltimore, Maryland 21215-0036

State Registrar

Kevin Gil, M.D. 31. Date filed (Month, Day, Year)

29b. Signature and title of certifie

30. Name and address of person

14816 Physicians Lane, #253, Rockville, Maryland 20850 32. Registrate Signat

who completed cause of death (Item 23a) (Type, Print)

and manner stated.

29c. License number

D35192

29d. Date signed (Month, Day, Year)

October 15, 2007

5	Dalumore, Mai yiamu 21213-0030		
Dh	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland	1	
	Department of Health and Mental Hygiene.	Fı Di	
oie	Important: If item 27 is marked other than "natural", or items 23a or 28a-f show	un re	Ēχ
·i-	any injury or other traumatic event, the Medical Examiner must be notified at	er ct	ar
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/Med Exami

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and Division or Vital Records, P.O. Box 68760,

DHMH 17 Rev 1/2001

		for State		State	of Mary	land / Dep	artmer <i>rtificat</i>				ental Hy	•			
_	-	Registrar 1. Decedent's Nan	me (First, Middl	e Last)			lillicat	e or i	Jean		2. Date of De	Reg. N	10. 2	107	$\frac{33230}{33230}$
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eral		5. Social Security		6. Sex	7	yrs. last birthday)	If Unde		If Under		8. Date of Bi	rth			place (State or Foreign
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ed at	or	MD.	N/			BALTIM								Ι.	1 ∰Yes 2 □ No
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st pe		4800 Y	ELLOWOO	D RD. AP	Г 211			2120	9				USA		
any injury or other traumatic event, t <u>he Medical Examiner must be notified at</u> once.	by Funeral		rned 2 Mar	ried Armed I	3 2 ⊈X No Give		Was Dece If Yes, spe 1 ☐ Yes	cify Cuba	ispanic Or in, Mexica Specify	in, Puerto	ecify Yes or No Rican, etc.)	0-		k, White,	ean Indian, etc. ACK
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t, the	Con	<u>-1´2-</u>		Ŏ-			CLER	K.		·.					URITY
even	Be	17. Father's Name	First, Middle, ROLLIN	•							First, Middle NE STA			ne)	
matic	ဥ	19a. Informant's N				19b. Maili	na Address	S (Street)			I Route Numb			State Zir	2 Code)
er trau				AN(SON)									,		AND 21117
r othe		20a. Method of Dis	sposition	2 □ Removal from		0b. Place of Dispo cemetery, cre	sition (Na	me of	- 1		ate		Location -		
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any in		21. Signature of F	uroral Service	Jich see JONA	KHAN/D	. Hibner	2. Name ai	nd Addres	s of Facil	ity RED	D FUNE	RAL	SERV	'ICÉ	
ian		23a. Part1. Ent r shock, by ne Immediate Cause disease or conditi	(Final	r complications that t only one cause on	t caused the each line.	death. Do not en	721-2 ter the mod	27 N. de of dyin	MON g, such as	ROE S s cardiac o	T. BAL or respiratory a	TIM arrest,	ORE,	MARY:	LAND 21217 Approximate Interval Between Onset and Death
ical ner		resulting in death)	Due to		nsequence of):	ilue	U	lces	(.1)	th M	ten	mya/	: Jic	,
-	ner	Se uentially list c if any, leading to i cause. Enter Und Cause Disease of	conditions immediate deriving	b. Due t	o (or as a cor	nsequence of):				00.	7.1	21 (0	10	1/2	
burial-transit	Examine	Cause (Disease of that initiated even resulting in death)	lS .	c. <u>Di</u>	a bet		11:40	2.							
burial		, , , , , , , , , , , , , , , , , , , ,	,	Due to	o (or as a cor	nsequence of):									
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completely filled in by the funeral director, page 2 should be detached for use as	Physician/Medical	IF FEMALE: 23b. Was decede in the past 1: 1 ☐ Yes 2 9 ☐ Unknow	2 months?	1□Live	outcome pf pr birth 2 gnant at time known	Fetal death 3	⊒Ectopic p ⊒ Other (s _i							te of delive	ery Day Year
be deta	þ	Part II. Other sign	ificant conditi	ons contributing to	death but no	t resulting in the u	inderlying o	ause give	en in Part	t.					he cause of death?
pinonia	eted											Yes	212 No	3 ☐ Prot	
, page 2 s	Completed										24a. Was auto perf 1 Yes			Were auto prior to co death? 1 ☐ Yes	opsy findings available impletion of cause of
irecto	o Be	25. Was case reference examiner? 1 ☐ Yes 2 ▼	erred to medica	Hospital:	Inpatient	2 ☐ ER/Outpatie	nt 3 □ D0	Othe	37'		(Check only		- 53-11		
erald		27. Manner of Dea	ath	28a. Dat	e of Injury	28b. Time o		28c. Injun Worl	4 ⊔ N		me 5 ☐ Res 28d. Describe			. , ,	fy)
e tu	atio	1 ☑ Natural 2 ☐ Accident	5 ☐ Pendir investi	gation	onth, Day Yea	ar) Injury	М		<br Yes 2□]No					
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pletely fill	Medical (29a. Certifier (Check only one)	1 Certifyii 2 Medical	ng Physician: To t Examiner: On the and ma	he best of my basis of exa anner stated.	y knowledge, deat mination and/or in	th occurred rvestigation	at the tir	ne, date a pinion, de	nd place, ath occurr	and due to the ed at the time	cause , date a	e(s) and ma and place,	anner as s and due t	stated. to the cause(s)
E 00	Σ	29b. Signature an	nd title of certifie	er V				c. Licenso		891	+6	^			Day, Year) 2007
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Sta gistr		31. Date filed (Mo	onth, Day, Year,	32.	Registrar's S	Signatur	1								
giott	204	UU	T (COI	11 /300	7	1									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 300 /Medical or Location of Death 4c. County of Deat Eacility Name (If not institution, give street and num **Examiner** If Under 1 Year | If Under Date of Bir 9. Birthplace (State or Foreign 8. Social Security Number 6. Sex Age (In vrs **Funeral** Days Min Months Hours 1 M 2 X F la Director ulano Usual Residence of Decedent death with the Maryland 10c. City. Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 1 Yes 2 No Director more 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Ton Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify ģ 3 ☑ Widowed 4 ☐ Divorced Completed 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 10 Tate 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Same 20b. Place of Disposition (Name of cemetery, crematory or other Date 20c. Location - City or Town, State 20a. Method of Disposition 1 M Burial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify) 3 ☐Removal from State 21. Signature of Funeral Service License 22. Name and Address of 23a. Party Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart dailure. List only one cause each line.

Immediate Cause (Final disease or condition resulting in death)

a.

Due to (or as a consequence of the condition or condition) Approximate Interval Between Onset and Death Physician /Medical Due to (or as a consequence Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner certificate be executed and burial-trar Due to (or as a consequence of): ending physician use as the buria Box 68760 Physician/Medical attending p IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Dav Year 4 Pregnant at time of death 5 ☐ Other (specify) signed by the a P.0. 9□Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an page 2 s this certificate or Attending Physician: director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) spital: 1 Impatient 28a. Date of Injury 1 Yes 2 No 2 ☐ ER/Outpatient 3□ DOA မှ funeral 27. Manner of De th 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural
2 Accident (Month, Day Year) Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No death. within 24 hours after death

To the Funeral Director: completely filled in by the f 6 ☐ Could not be 3□ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, vale and place, and due to the cause(s) and manner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32

31. Date filed (Month, Day, Year)

OCT 1 7 2007

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** OCTOBER ROSALIE ALMARETTA DAVIS 8:00P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HOLY CROSS HOSPITAL MONTGOMERY SILVER SPRING If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 □ M **X**(X) F 159 32 3684 88 MAY 01, 1919 FLORIDA Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State show r than "natural", or items 23a or 28a-f shov the Medical Examiner must be notified at 1XXYes 2 □ No Director DC WASHINGTON 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 104 FORT DRIVE, NORTHEAST #1 20011 UNITED STATES Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene.

Int. If Item 27 is marked other than "natural", or ite any or other traumatic event, the Medical Examine. 1 ☐ Yes XX No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0036 1 ☐ Yes XX No Specify: Specify: BLACK þ ₩Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) DISTRICT OF COLUMBIA Elementary/Secondary (0-12) College (1-4or 5+) SCHOOL TEACHER PUBLIC SCHOOLS 4+ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ROSA STRAUGHTER ပ JAMES D. COLE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s Department of Health ar Important; If Item 27 is any injury or other trau once. CAPITOL HEIGHTS, MD 20743 IONA B. WILLIAMS / FRIEND 7001 ONYX COURT 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State XX Burial 2 Cremation 3 ☐Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 10/18/2007 ROCK CREEK CEMETERY WASHINGTON, DC 21. Signure of Foleral Service Licensee 22. Name and Address of Facility
MARSHALL'S FUNERAL HOME OF MARYLAND, Mlan 4308 SUITLAND ROAD SUITLAND, MD 20746 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediale Cause (Final disease or condition SEPSTS Approximate Interval Between Onset and Death Physician disease or condition resulting in death) SEPSIS /Medical Due to (or as a consequence of): Examiner BRAIN LESIONS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed sician Ind burial-trans SACRAL DECUBITUS Due to (or as a consequence of) Physician/Medical attending physic for use as the b 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes ※XXNo Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) certificate has been signed by the rector, page 2 should be detached 9 Unknown 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably XXUnknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1□ Yes XX No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes XX No 1XXnpatient P 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) Medical Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No

Division or Vital Records, P.O. Box 68760, Hospital or Attending Physician: after death.

I Director: After this ced in by the funeral director. filled 124 hours a within 24 hou To the Fune completely fil To the

2 Accident

29b. Signature and title of certifier

3 ☐ Suicide 4 Homicide

29a. Certifier

6 □ Could not be determined

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

XX Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number 29d. Date signed (Month, Day, Year) 20056063

30. Name and address of person, ho completed cause of death (Item 23a) (Type, Print)

and manner stated

KANWALJIS NAGI, M.D. 31. Date filed (Month, Day, Year)

7 2007

1500 FOREST GLEN ROAD

SILVER SPRING, MD 20910

28f. Location (Street and Number or Rural Route Number, City or Town, State)

State Registrar

32 Registrar's Signature

			State of N	Maryland / Depa <i>Cer</i>	artment of H	ealth and Meni	tal Hygiene Reg. No	2007	33233
R			1. Decedent's Name (First, Middle, Last)		imouto or i	2. 🗆	ate of Death		3. Time of Death
	Physici /Medic		Elliott Daugh				lonth Da	2007	1:30a. M
)	Examir Funeral Director	er	215-30-4438	Age (In yrs. last birthday) 73 Yrs.	4b. City, Town, or Baltir If Under 1 Year Months Days	More If Under 24 Hrs. 8. D	ate of Birth Month, Day, Year)	Cou	place (State or Foreign ntry)
	vland ow		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Loc	cation			1	10d. Inside City Limits
	e Many ka-f sh tified a	ctor	MD N/A	Baltim	nore				1x Yes 2□No
	with th a or 28 be no	Director	10e. Street and Number		10f. Zip Code		10g. Ci	tizen of What Cou	ntry?
	death ms 23 r must	Funeral	769 McKewin Avenue 11. Marital Status 12. Was Deceder	nt Ever in U.S. 13. V	21218 Vas Decedent of Hi	3 spanic Origin? (Specify ` n, Mexican, Puerto Ricar	Yes or No-	USA 14. Race - Ameri	
036	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f show he Medical Examiner must be notified at	by	Armed Force: 1 □ Never Married 2 □ Married 1 ☒ Yes 2 □ 3 ☒ Widowed 4 □ Divorced Year or Dates] No 1	i fes, specily Cuba I ☐ Yes 2 🙀 No	Specify:	1, etc.)	Specify: B	_{etc.} lack
21215-0036	"natur edical	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Deced	lent's Usual Occupa	ation furing most of working)	16b. K	(ind of Business/Ir	dustry
2121	d withir giene. r than the Me	dwo	Elementary/Secondary (0-12) College (1-4o	or 5+)	ege of No			0170010	ui aou
	be filectal Hyg d othe	Be	17. Father's Name (First, Middle, Last)		ege of No	18. Mother's Name (Firs		,	VISOE
Maryland	thould and Men	၉	Cassie Lee Daughtry 19a. Informant's Name/Relationship (Type. Print)	1	a Address (Street a	Ollie and Number or Rural Roo	Bell	Evans	n Code)
	and 2 saith ar saith ar 27 is er trau		Elliott Daughtry, Jrso			Avenue Balt:			o code)
altimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1 → Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)	te 20b. Place of Disposer cemetery, cren Crownsvi	sition (Name of natory or other place 111e VA Ce	em. 10/19/2		ocation - City or To Ownsville	
Balt	permit. Departi Import any inj		21. Signature of Funeral Service Licensee		. Name and Addres	s of Facility MA Orth Avenue	RCH FUNF	ERAL HOME	
Malical Co.	Physician /Medical Examiner	<u>-</u>	Sequentially list conditions b.	sed the death. Do not ente	er the mode of dying	g, such as cardiac or res	piratory arrest,	e/ MD	Approximate Interval Between Onset and Deaths
€8760,♥	eath certificate be executed attending physician and for use as the burial-transit	edical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last C Due to (or a	as a consequence of):	- 4				
P.O. Box	The law requires that the death certi te has been signed by the attending bage 2 should be detached for use a	Physician/M		2 Fetal death 3 at time of death 5	Ectopic pregnancy Other (specify)			23d. Date of deliv Month	ery Day Year
	w requires that the de been signed by the a should be detached f	by	Part II. Other significant conditions contributing to death	but not resulting in the un	nderlying cause give	en in Part I.			he cause of death? bably 4 □Unknown
Vital Records,	The law recate has been page 2 sho	Completed					24a. Was an autopsy performed?	prior to co death?	opsy findings available impletion of cause of 2 □ No
VIII VIII	ysiclan; The is certificate hadirector, page	Be	25. Was case referred to medical examiner? 1 ☐ Yes 3 ☐ No Hospital: 1 ☐ Inpa	atient 2 ☐ ER/Outpatient	t 3 DOA Othe	26. Place of Death (Cheer:	2		
Division or	nding Phys th. : After this s funeral di	tion: To	27. Manner of Death 28a. Date of Ir		28c. Injury Work	7 4 ☐ Nursing Home 7 at 28d. I 7 27 7 es 2 ☐ No	Describe how inju		fy)
Divisi	al or Attences after death	Certification:	3 Suicide 6 Could not be 28e. Place of i	injury - At home, farm, streetc. (Specify)	eet, factory, office		ocation (Street ar City or Town, State	nd Number or Run e)	al Route Number,
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director. It	Medical C	29a. Certifier (Check only one) Certifying Physician: To the best and manner and manner	of examination and/or inv	occurred at the time vestigation, in my of	ne, date and place, and c pinion, death occurred at	lue to the cause(s the time, date an	s) and manner as s od place, and due t	stated. to the cause(s)
	To th To th COFF	ž	29b. Signature and title of certifier		29c. License			ate signed (Month,	
		1	30. Namu and address of person who completed cause of	I double (H 00:) (T	10 A)	1944	ا٥ر	tobsen 1.	5,2007
	HXI		STANLEY Walker 33	JJON EE	Colum	t sheet 1	Ballin	none n	1,2007
	Sta Registr		31. Date filed (Morth, Day, Year) 0CT 1 7 2007	strar's Signature	de				<u> </u>

State

2007

OCTOBER

JOSEPH DUNI

DHMH 17 Rev 1/2001

Registrar

ORIGINAL

TIMONIUM, MD 21093

2300 DULANEY VALLEY RD.

32 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR. TARIQ MAHMOOD

OCT 1 7 2007

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** Larry Robert Edward DiMattei, Sr. October 15, 2007 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Middle River Baltimore 204 East Kingston Park Lane Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months Days Hours **1√2√**M 2 □ F 53 01/20/1954 Maryland Director 213-62-6732 Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10a, State r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2√ No Middle River Director Maryland Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21220 U.S.A. 204 East Kingston Park Lane Completed by Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ★ Married 1 ☐ Yes 2 ☐ No Specify. Specify: White Maryland 21215-0036 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Residential al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Drywall Finisher Construction 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be nd 2 should be filth and Mental H 27 Is marked of r traumatic ever permit. Pages 1 and 2 should be Department of Health and Mental Important: If Item 27 Is marked of any lighty or other traumatic even once. Jean Brenda Hunter Joseph George DiMattei 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21220 19a. Informant's Name/Relationship (Type. Print) LaDonna Rae DiMattei - Wife 204 East Kingston Park Lane Middle River, Maryland Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 10/19/2007 Middle River, Maryland Holly Hill Memorial 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Bruzdzinski Funeral Home P.A. 21. Signat Funor Formation icensee 1407 Old Eastern Avenue Essex, Maryland 21221 pt. The disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, r heart failure. List only one cause of each line. Approximate Interval Between Onset and Death Immedi & Cause (Final diseas or condition resulting in death) **Physician** /Medical Die to (or as a consequence of): **Examiner** Sequentially list conditions, if any, is a ling to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to [or as a consequence of): Examine death certificate be executed physician and s the burial-transit Due to (or as a consequence of) Box 68760, Physician/Medical as attending IF FEMALE: for use 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐Live birth 2 Fetal death 3 ☐ Ectopic pregnancy Year Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) 4□Pregnant at time of death P.O. cate has been signed by the page 2 should be detached 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an 1∏ Yes rector, 26. Place of Death (Check only 25. Was case referred to medical Other: Hospital: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 3□ DOA 1 Inpatient 2 ER/Outpatient ို funeral dir 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death Certification: 5 Pending investigation Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 4 Homicide

within 24 hours after death

To the Funeral Director:,
completely filled in by the f To the Hospital

State

30. Name and address of person who complete cause of death (Item 23a) (Type, Print) ALLE M

and manner stated

Registrar's Signature

29d. Date signed (Month, Day, Year)

Registrar

Medical

29a. Certifier

(Check only

29b. Signature and title of certifier

certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

			1 - For State Registrar	State of Ma	ryland / Depa <i>Cei</i>	artment of H	lealth and I Death		ene2007	33236
ı	Physici		Decedent's Name (First, Middle, I WARREN	B. EVAI	NS			2. Date of Death	Day Zoyear	3. Time of Death
	/Medic Examir		4a. Facility Name (If not institution, g				r Location of Deatl	h	4c. County of Deat	
	Funeral			15DM 2DE	(In yrs. last birthday) Yrs.	TOWSOI If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y	Balti (ear) Balti (co	more hplace (State or Foreign untry)
-	Director		220–42–8209 Usual Residence of Decedent	1 X 2 6	0			5 30	1947	MD
	Aarylar f show	ō	10a. State 10b. County N/	Δ	10c. City, Town or Lo Baltim					10d. Inside City Limits 1√√√√√√√√√√√√√√√√√√√√√√√√√√√√√√√√√√√√
	with the N 3a or 28a- It be notifi	Funeral Director	10e. Street and Number 717 Bartlett		DOTCIN	10f. Zip Code 212]	 18	100	g. Citizen of What Co USA	177
36	is 1 and 2 should be filed within 72 hours after death with the Maryland if health and Mental Hygiene. If the sith and Mental Hygiene, if the sith and the sith and the standard other than "naturel", or items 23a or 28a-f show other traumatic event, the Mudical Examinat must be notified at	by Funera	11. Marital Status 1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 No. If Yes, Give Year or Dates:	0	Was Decedent of H f Yes, specify Cuba	ispanic Origin? (S an, Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)	14. Race - Ame Black, White Specify:	
15-0036	in 72 hou n *nature	Completed	15. Decedent's (Specify only highest of	Education grade completed)	(Give	dent's Usual Occup kind of work done o DO NOT use retired	ation during most of wor	rking	Sb. Kind of Business/	
2121	filed with Hygiene. ther ther	Comp	Elementary/Secondary (0-12) 12th	College (1-4or 5- N/A	-)	ployed			N/A	
	uld be fill Aental H rked oth tic even	To Be	17. Father's Name (First, Middle, La: Johnny W.	Evans			18. Mother's Nam	me (First, Middle, Ma Zimme		
Mary	od 2 should th and Men 27 Is marke traumatic		19a. Informant's Name/Relationship Wallace Evans-br					ral Route Number, C timore, M	City or Town, State, 2 D 21205	(ip Code)
9	Pages 1 and 2 nent of Health int: If Item 27 I iry or other tra		20a. Method of Disposition 1 Surial 2 Cremation 3		20b. Place of Dispo- cemetery, cren	sition (Name of natory or other place	ee)	Date 20	c. Location - City or	
saltin	permit. Pages Department of Importent: If it eny injury or o		4 Donation 5 Other (Spec		Trinity 22				Baltimore AL HOME-E	MD AST
m	40 E 5 9		23a. Part1. Enter the disease, or co	mplications that caused t		101 E. No			more, MD	21202 Approximate
F	Physician /Medical		shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)	ty one cause on each line a.		-	1	ccidon		Interval Between Onset and Death
	Examiner		Sequentially list conditions,	Due to (or as a	consequence of):					
P.	uted d ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a	consequence of):					
58760,2	ricate be executed physician and s the burial-transit		resulting in death) Last	Due to (or as a	consequence of):					
		Medical	IF FEMALE:	0.						
O. Box	at the death certification by the attending stached for use as	by Physiclan/M	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome o 1 □ Live birth 2 4 □ Pregnant at ti 9 □ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of deli Month	very Day Year
ds, r	igned be de		Part II. Other significant conditions	contributing to death but	not resulting in the un	nderlying cause give	en in Part I.		cco use contribute to	the cause of death?
Hecords,	ine law rec	Completed		Anem	16			24a. Was an autopsy performe	prior to c	topsy findings available completion of cause of
	ysician: ine law is certificate has t director, page 2 s	BeC	25. Was case referred to medical examiner?	-			26. Place of Dea	1 ☐ Yes 2 ☑ th <i>Check only</i> one	No 1 ☐ Yes	2 No
5		유	1 ☐ Yes 2 💢 No 27. Manner of Death	Hospital: 1 Inpatien 28a. Date of Injury (Month, Day		t 3 DOA Othe	Nursing H	ome 5 Residence	ce 6 Other (Specinjury occurred	eify)
UNISION	death. death. nctor: After th y the funeral	Certification;	2 Accident investigati 3 Suicide 6 Could not	on be go Blassetts	y - At home, farm, stre	M 10'	Yes 2□No	28f. Location (Stree	et and Number or Ru	ral Route Number
בֿ	ours after eral Dire		4 Holiticide	building, etc.	(Specify)			City or Town, S	State)	
1	within 24 hours after deatl To the Funeral Director: completely filled in by the	Medical	one)	Physician: To the best of aminer: On the basis of and manner state	examination and/or inv	estigation, in my of	oinion, death occu	, and due to the caus rred at the time, date	se(s) and manner as and place, and due	stated. to the cause(s)
,	with Court	2	29b. Signature and Mile of certifier Att	Odding P.	Merion	29c. License	1366 5366	29d	Date signed (Month	Day, Year)
	9-		30 Name and address of person who	completed cause of dea	ath (Item 23a) (Type, F	Print)	157	4202 E	Bultims	2/204
	Sta Registr		31. Date filed (Month, Day, Year) OCT 1 7	32. Registrar	's Signature	ander				,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 33237 For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician Keith Lennie Edwards** 2:30 a Oct 13, 2007 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner N/A **Baltimore** Joseph Richey Hospice, Inc. 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Months 1 ₩ 2 F Director Maryland 218-78-1218 Jan 8, 1958 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Marylar 28a-f show must be notified at 1 Yes 2 No Wake Raleigh Director N.C. 10e, Street and Number 10g. Citizen of What Country? 10f. Zip Code Pages 1 and 2 should ba filed within 72 hours after death with ō 6121 Forestville Road 27604 U.S.A. 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) or items 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ **X**io Specify. Specify: Black þ 3 ☐ Widowed 4 ☐ pivorced 'natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry the Muc Elementary/Secondary (0-12) College (1-4or 5+) North West Nursing Home Janitor 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) n and Mental Fis marked ot Be Jean E. King James Edwards ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health al important: If item 27 is any injury or other trau 6121 Forestville Road Raleigh, N.C. 27604 Peggy King 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ gremation 3 ☐ Removal from State 10/16/07 Catonsville, Maryland 5 ☐ Other (Specify) Metro Crematory, Inc. 4 Donation 22. Name and Address of Facility f Funeral Service Estep Brothers Funeral Service, P. A. 1300 Futaw Place Baltimore, Md 21217 Part1. Enter the diseas shock, or heart failure. disease, or complications that caused the failure. List only one cause on so line. Do not enter the mode of dying, such as cardiac or respiratory arrest Immediate Cause (Final Physician disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 5 ☐ Other (specify) 9☐Unknown 9 Unknown signed by t 1 be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. cco use contribute to the cause of death? ğ 1 Yes 2□ No 3 Probably 4 ☐Unknown Completed 24a. Was an autopsy Were autopsy findings available prior to completion of cause of death? certificate 2 🗌 No 1∐ Yes 2 4 the Hospital or Attending Physician: 25. Was case referred to edical Be 26. Place of Death (Check only one) examine Other: 1 🗆 Yes 2 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence မှ 1 ☐ Inpatient After this 28a. Date of Injury (Month, Day Year) r of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation Injury 1 Natural 1 ☐ Yes 2 □ No 2 Accident Director: To unce within 24 hours and To the Funeral Director 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License numbe 29b. Signature and title of certifie

State Registrar 31. Date filed (Month.

Day.

2007

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death October 13, 2007 Physician Barbara Leef Erdley 10:00 PM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Manor Care Potomac Montgomery Potomac Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday, If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Social Security Number **Funeral** Days Months Hours 1 □ M 2 T F July 7, Director 220-28-6334 1932 75 Washington, D.C Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 ☐ Yes 2X No Directo Maryland | Montgomery Darnestown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 15201 Springfield Road 20874 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛛 No Specify: White þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Montgomery County Elementary/Secondary (0-12) College (1-4or 5+) 2 Teachers Aide Public Schools 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Thomas N. Leef P Dorothy Franklin 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Randall G. Erdley/Husband 15201 Springfield Road, Darnestown, MD 20874 20b. Place of Disposition (Name of cemetery, crematory or other place) Montgomery 20a. Method of Disposition 20c. Location - City or Town, State October 17, 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 22. Name and Address of Facility Robert A. Fumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue 4 □ Donation 5 □ Other (Specify) Crematorium, Inc. 21. Signature of Funeral Service Licenses M01346 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** METASTATIC SKIN CANCER /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-tra-hash. Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🖼 Yo Month 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performe death? 1 ☐ Yes 1 Yes 2 🖫 Vo 2 Day 25. Was case referred to medical examiner? 26. Place of Death | Check only one) Hospital: 1 ☐ Inpatient Other: 4 Aursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 2 No 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 ∰Natural Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

State

Registrar

Medical

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

29a. Certifier

(Check only one)

OCT 1 7 2007

Truong Bao, M.D., 9715 Medical Center Dr. #201, Rockville, MD 20850 32: Registrar's Signature

o mo

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

l 🗜 ُ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

00057124

29d. Date signed (Month, Day, Year)

10116107

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Date of Death
 Month 1. Decedent's Name (First, Middle, Last) Day **Physician** Arnold Romulo Franceschini 2007 0932 October 0 11, /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Suburban Hospital Bethesda If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Days Hours Min. (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 M 2 □ F Yrs. Director 218-94-5525 85 March 17, 1922 Argentina Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show at be notified Director 1 ☐ Yes 2 ☑ No Maryland Montgomery Potomac 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? ō items 23a must 20854 Funeral 9821 Glen Road United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any Injury or other traumatic event, the Medical Examiner once. Black. White, etc. 1 □ Never Married 2 1 Married Baltimore, Maryland 21215-0036 1 X Yes 2 □ No Specify: Argentinean ģ Specify: White 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry
Inter-American 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Development Bank Economist 5+ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဥ Juan Dante Franceschini Geraldine Marham 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Angela Franceschini / Wife Glen Road, Potomac, Maryland 20854 20b. Place of Disposition (Name of cemetery, crematory or other place)
Gate of Heaven
Cemetery 20a. Method of Disposition October 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 2007 4 Donation 5 Dother (Specify) Silver Spring, Maryland 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase. Inc., 7557 Wisconsin Ave. Bethesda, Maryland 20814-3501 21. Signature of Funeral Service Licensee M. M01473 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Aspiration Pneumonia resulting in death) /Medical Due to (or as a consequence of): **Examiner** Congestive Heart Failure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Exami physician and s the burial-trans Head and Neck Cancer Due to (or as a consequence of) P.O. Box 68760. Physician/Medical Gastric Tube Feeding as IF FEMALE: nse 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) ed by the a detached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 😿 Unknown Dementia page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1□ Yes 2☑ No 1 ☐ Yes 2 ☐ No Division or Vital 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA After this 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) Injury 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation after death Director; the 3 ☐ Suicide 6 Could not be determined Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) à 4 Homicide filled in 24 hours a 29a. Certifier 1 💆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) within 2 To the the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D20274 October 12, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7710 Bradley Boulevard, Bethesda, Maryland 20817 Kirti Vohra, M.D. 31. Date filed (Month, Day, Year) Registrar's Signature State 7 2007 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death **Physician** arrow JR. 2007 0 /Medical 4b. City, Town, or Location of Death 4c. County of Death **Examiner** . + Maryland Med BALTIMORE N/A University If Under 24 Hrs. 8. Date of Birth Hours Min. SEPT. If Under 1 Year Social Security Number 9. Birthplace (State or Foreign **Funeral** 1,1946 MARYLAND Days **X** M 2□F Months 214-40-0738 61 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f shov any Injury or other traumatic event, the Nedical Examiner must be notified at 1 ☐ Yes 2 No Director MD BALTIMORE CHASE 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 8107 DOGWOOD ROAD 21219 U.S.A. death v 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 Never Married Married Maryland 21215-0036 1 ☐ Yes 2 No ģ Specify: WHITE 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) IRON WORKER CONSTRUCTION 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) nin and Mental F. Pages 1 and 2 should be JULIUS R. FARROW, ASSUNTA IANNANTUONO 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) TERRI GILBART/ DAUGHTER 1240 E. FORT AVENUE, BALTIMORE, MARYLAND 21230 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 【▼Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) BAYVIEW CREMATORY 10/9/07 BALTIMORE, MARYLAND LTLLY & CETLER INC. FUNERAL HOME 1901 EASTERN AVENUE, BALTIMORE, MD. 21. Signature of Funeral Service Licenses 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Tangrenous choleushtu /Medical Due to (or w a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed physician and s the burial-trans Physician/Medical as IF FEMALE: for use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ cate has been signated by page 2 should b 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) examiner? 1 X Yes 2 ☐ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28b. Time of 28c. Injury at Work? 27. Manner of Death Date of Injury (Month, Day Year) 28d. Describe how injury occurred 1 Natural 2 Accident Injury investigation

Division or Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: After this death. s after death

filled in by

within 24 hours at To the Funeral D completely

State Registrar

Medical

29a. Certifier (Check only one) 29b. Signature

3 ☐ Suicide

4 Homicide

1 ☐ Yes 2 ☐ No 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

🗓 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name a

Baltimore, MD 21201, Cutter Hamilton Holfon II MD

31. Date filed (Month, Day, Year, OCT 1 6

6 ☐ Could not be determined

State of Maryland / Department of Health and Mental Hygieney 1 - For State Registrar Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 45pm **Physician** me 0 a JOI **/Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Baltimore City Mercy Medice
5. Social Security Number 6. Sex Himore If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Year) May 1,1953 7. Age (In yrs. last birthday) Hours **Funeral** Months Days 1 ☐ M 2 🔀 F Pennsylvania 54 195-44-2941 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10h. County show "natural", or items 23a or 28a-f shovidical Examiner must be notified at 1 ☐ Yes 2 XNo Directo Columbia Maryland Howard 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21045 U.S.A. 8725 Endless Ocean Way Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: filed within 72 hours after 1 ☐ Never Married 2 ☐ Married Specify: White 1 ☐ Yes 2X No Saltimore, Maryland 21215-0036 3 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) Howard Community College (1-4or 5+) Elementary/Secondary (0-12) marked other than College Professor permit. Pages 1 and 2 should be file.
Department of Health and Mental Hyg. Important: If item 27 is marked other any Injury or other traumestingonee. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Dolores Breski Jerome W. Makowski 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 8725 Endless Ocean Way Columbia, MD 21045 Andrew C. Goresh (Husband) 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 10-17-2007 Catonsville, MD Metro Crematory 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Witzke Funeral Homes, Inc.
5555 Twin Knolls Road Columbia, MD 21045 21. Signature of Funeral Service License 23a. Part. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) rine **Physician** ite /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine the Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical attending pl 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death nse 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month in the past 12 months? 5 Other (specify) 1 ☐ Yes 2 X No 9 ☐ Unknown ate has been signed by the page 2 should be detached 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 3 Probably 4 ☐Unknown 2 No 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 2 □ No 1 ☐ Yes 2 No 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 No ပ this 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury 28c. Injury at Work? Certification: After (Month, Day Year) injury 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 Suicide determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of pertifier AU417643517670 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) Center 301 St. Paul Place Baltimore MD 21201 Medical VO1 31. Date filed (Month, Day, Year) State OCT 1 7 2007 Registrar

AMEND TEM/19b per HL 872, 10/17/07 US State of Maryland Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 2:24 D.M **Physician** Graham Sr. Billy J. ctobe /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner altimor ave If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Days Hours Min. (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 1 XM 2 □ F Months 212-42-4758 61 MD 02 Director Usual Residence of Decedent 10d. Inside City Limits 72 hours after death with the Maryland 10c. City, Town or Location r 28a-f show notified at 10a. State 10b. County 1X Yes 2 No Baltimore MD NA Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number "natural", or Items 23a or U.S.A. 21207 6301 Monika Place Apt 1201 Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 □ Yes 2 N No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black. White, etc. 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify Specify: Black þ 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) the Medical (Give kind of work done during most of working life. DO NOT use retired) filed within 7 I Hygiene. other than "r Elementary/Secondary (0-12)
12th grade College (1-4or 5+) Ship Trade Assoc. Longshoreman permit. Pages 1 and 2 should be filed will Department of Health and Mental Hygient Important: If item 27 is marked other than any injury or other traumatic event, the I once. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pearl Goodman Henry Graham ပ 19b. Mailing Address (Street and Nymber or Runal Poute Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 72 Comet Ct, Parkveille Md 21234 Billy Graham Jr.-Son Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Quantion 5 ☐ Other (Specify) Metro Crematory Inc 10/15/07 Baltimore, Md 21. Sign wure of Funeral Service Licensee March F/H West 21215 4300 Wabash Ave, Baltimore, 23a. Part1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest short, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician myor Due to (or as a consequence f): /Medical **Examiner** alonory if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner certificate be executed burial-trar Due to (or as a consequence of): attending physician P.O. Box 68760 Physician/Medical the for use 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9☐Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 22 No 1□ Yes director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes No 1 🔲 Inpatient 2 ER/Outpatient 3 □ DOA Certification: To funeral 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No Hospital or Attendi 24 hours after death. s Funeral Director; A etely filled in by the fi 2 ☐ Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical the 29c. License numbe 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2 Name and address of person who completed cause of death (Item 23a) (Type, Print) 32. Registrar's Signature 5 31. Date filed (Month, Day, Year) State 7 2007 OCT 1 12000 Registrar

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		,	For State Registrar		State of M	aryland	-	artment of F rtificate of I		Mental Hy	giene Reg. No.	2007	33243
ţ		7	Decedent's Name	(First, Middle, Last)					2. Date of De			3. Time of Death
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	Examin	er	4a. Facility Name (If)			Location of Death	1	4c.	County of Death	
	Funeral	1.	5. Social Security Nu			ge (In yrs. I	ast birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Bir	rth	Bell+i	place (State or Foreign
ľ	Director		526-11-47	152 ¹²	≰ M 2□F	50	Yrs.	Months Days	Hours Min.	(Month, Da	19, Year)	57 Mes	ryland
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42	be filed within 72 hours after death with the Maryland ntal Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	S	17. Father's Name (/	First, Middle, Last)				Carpent	18. Mother's Nan	ne (First, Middle	1		CTION
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ary	2 should and Men is marke aumatic		19a. Informant's Nar					ng Address (Street		A.	per, City o	or Town, State, Z	ip Code)
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altimore,	permit. Pages 'Department of H Important: If ite any injury or of		1 ☐ Burial 2 ☐	☐Cremation 3 ☐I				sition (Name of matory or other place F+5 Regis		-12, 2007		nover, N	
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ľ				t failure. List only o	ne cause on each	line.			-				Approximate Interval Between Onset and Death
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687	ificate g phys as the	edical			d								
Box	death certifice attending phater	Physician/M	IF FEMALE: 23b. Was decedent	pregnant	23c. If yes, outcom 1 □ Live birth			Ectopic pregnancy	,			23d. Date of deli	
O. E	ne dea the att hed fo	/sici	in the past 12 r 1 ☐ Yes 2 ☐ 9 ☐ Unknown		4□Pregnant 9□Unknown			Other (specify)				Month	Day Year
P.O.	res that the de signed by the a be detached f		Part II. Other signifi	cant conditions	ntributing to death	but not resu	ulting in the u	nderlying cause giv	en in Part I.	23e. Did	tobacco u	use contribute to	the cause of death?
rds	w requires been sign should be	d by								10	Yes 2	☑No 3□Pr	obably 4 Unknown
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Division or	nding Physician: The la th. r: After this certificate has e funeral director, page 2	: To	1 ☐ Yes 2 ☑ 1 27. Manner of Death	NO	28a. Date of In	jury	28b. Time o	IL SEL DOA	4 ⊔ Nursing H	lome 5 ☐ Res 28d. Describe		6 ⊡ Other (Spec ry occurred	city) Hospice
on	ath. rr: Afte re fune	atior	1 ☑ Natural 2 ☐ Accident	5 ☐ Pending investigation	(Month, D	ay Year)	Injury		k? Yes 2 □ No				
<u> </u>	or Atte ter de irecto n by th	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e. Place of in building, e	njury - At ho etc. <i>(Specif</i>)	me, farm, st	reet, factory, office		28f. Location City or To	(Street an own, State	nd Number or Ru e)	ıral Route Number,
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	To the Hospital or Attending Physician: The law requires that the death certifulin 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Medical		2 Medical Exam		of examina							
	To th Withir To th	Me	29b. Signature and	title of certifier	10			29c. Licens				te signed (Monti	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2007 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** AILEEN R. GAY **OCTOBER** 2007 /Medical 10:05A 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner OAK CREST CARE CENTER BALTIMORE COUNTY BALTIMORE 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthdav) **Funeral** Days 1 M X X F Director 218-40-2195 83 Oct. 11, 1924 New York Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits ral", or items 23a or 28a-f show Examiner must be notified at MYYes 2 No Director Maryland Baltimore City Baltimore City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2503 Gibbons Avenue Funeral 21214 USA Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hyglene.
Murt. If flew Z7 is marked other than "natural", or items 23.
Muy or other traumatic event, the Medical Examiner must ury or other traumatic event, the Medical Examiner must 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 YNo altimore, Maryland 21215-0036 Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 yrs. College (1-4or 5+) Registered Nurse Hospital 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Thomas C. Kelly Sara McAlinden 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: If item 27 is any Injury or other trau Margaret Cullum (Daughter) 7005 Beech Avenue Baltimore, Md. 21206 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition 20c. Location - City or Town, State XXXBurial 2 Cremation 3 Removal from State Parkwood Cemetery 10-15-2007 |Baltimore, Md. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Lassahn Funeral Home 7401 Belair Rd. Baltimore, Md. 21236 21. Signature of Funeral Service Licensee E. 7. assakn 0 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** 3400KB disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner ial Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examine The law requires that the death certificate be executed Due to (or as a consequence of) attending physician for use as the buria Division or Vital Records, P.O. Box 68760 by Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 □ Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 No 9□Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed 24a Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No has 1□ Yes Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2⊠No 2 1 🗌 Inpatient 2 ER/Outpatient 3 DOA To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 5 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8800 100 31. Date filed (Month, Day, Year) 32, Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

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\geq	2 should be and Menta is marked raumatic ev	-	19a. Informant's Name/Relationship		19b. Maili	ng Address (Street a	and Number or Ru	ral Route Numb	er, City or T	Town, State, Zip	Code)
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ā,	es 1 and 2 should b of Health and Ment f Item 27 is marked ir other traumatic e	1	20a. Method of Disposition	20b.	Place of Dispo	osition (Name of matory or other place	e)	Date	20c. Loca	ation - City or To	own, State
Ë	Page ient c nt: If ry or		1 Burial 2 Cremation 3 4 Donation 5 Other (Spec	Hemoval from State		n Cemeters	1	8/2007	Ball	ltimore.	Marvland
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33246 1 - For Stete Registre Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death **Physician** HOWARD F HUDGINS 15 2332 10 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner BALTIMORE, MARYUTUD

If Under 1 Year If Under 24 Hrs. Min. Min. June 20, 1932 JOHNS HOPKINS BAYVIEW MEDICAL CENTER 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 X M 2 □ F 219-28-4614 Yrs. Director 75 Maryland Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a State 10b. County ir then "naturei", or iteme 23a or 28a-f ehov If e Mudical Exarchier must be notified at 1 ☐ Yes 2 ☐XNo Maryland Baltimore Director Dundalk 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7103 Dunshire Way Apt A3 21222 USA Funera 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 20 No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) within 72 hours after 1 Never Married Married SpecifyWhite Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 years Service Technician Apartment Complex 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mental Pages 1 and 2 should be John Hudgins Mary Lena Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) it of Heelth Deborah Pigott Step-daughter 7183 Alder Spring Way, San Jose, CA. 95139 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State October 16. 5 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Department of Important: If any injury or once. Baltimore City, MD. Bayview Crematory 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Juneral Service License 22. Name and Address of Facility Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, Md. 23a. Part). Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shook, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CAREDIAC ARREST **Physician** /Medical Due to (or as a consequence of): Examiner CORDNARY ARTERY DISTAGE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine physicien and s the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760 Physician/Medical use as 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy ō Month Day 4□Pregnant at time of death 5 Other (specify) signed by the a o 9 Unknown 9 Unknown ے Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed certificete 1 ☐ Yes 2 No 2 No 1 ☐ Yes of Vital o the Hospital or Attending Physician: director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 Yes 2 No 1 🗌 Inpatient 2K ER/Outpatient 3 DOA this After thi 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Medical Certification: 28d. Describe how injury occurred **Division** 1 X Natural 5 Pending after death. investigation 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Thomicide within 24 hours a
To the Funerel C 18 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number Dr. Cleicia Mack **RES-3000** October 16,2007 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4940 EASTERN AVENUE BALTIMORE MARY LAND 21224 Dr. ALEICIA MACK 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Delesa OCT 1 7 2007 Registrar

DHMH 17 Rev 1/2001

BRUCE HEINLEIN Baltimore, Maryland 21215-0036 Division or Vital Records, P.O. Box 68760,

ician	Pleas 1 - For Amend #29d Per Registrar 1. Decedent's Name (First, Middle,	Local	leir			2. Date of Dec Month October	ath d Day	ZUU / Year	3. Time of Ceatr 4:05 P
dical niner	4a. Facility Name (If not institution,	give street and number)		4b. City, Town, o	or Location of Death		4c. C	county of Deat	h
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State of Maryland / Department of Health and Mental Hygiene

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Physici Medical Exam							Date of Death Month D October 14,					3. Time o 0538	
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imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. To the translatic event, the Medical Examiner must be notified at once.		Usual Residence of Decedent 10a. State 10b. County Maryland 10c. Street and Number 400 Dale Avenue 11. Marital Status 1 Never Married 2 Marr 3 Widowed 4 Divor 15. Decedent's Education (Specific Elementary/Secondary (0-12) 12th grade 17. Father's Name (First, Middle, Long and Specific Middle, Long and Specific Elementary Specific Middle, Long and Specific Middle, Long	nt Ever in U.s s? 2 No completed)	Town or Location Baltimore County 10f. Zip Code 21206 S. 13. Was Decedent of Hispanic Origin? (Specify Yes or Nolif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 X No specify: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Office Manager 18. Mother's Name (First, Middle, Maiden Surname Josephine Grabowski 19b. Mailing Address (Street and Number or Rural Route Number, City or Tow 926 Sidehill Dr. Bel Air, Md. 210				- American Indian, Black, , etc. White siness/Industry ting n, State, Zip Code)					
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/Medical xaminer xaminer	ical Examiner	failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) X UNPENDED Drowning Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): d. AMENDED AMEN								Derwee	en Onset and Death		
Records, P.O. Box 68760, The law requires that the death certificate be are has been signed by the attending physici page 2 should be detached for use as the buril	npleted by Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 ✓ Unknown Part II. Other significant condition	23c. If yes, outcome 1 Live birth 4 Pregnant 5 Unknown	at time of dea	ath 5 Oti	tal death her (Specify)	3	Ectopic pr	egnancy		2 No 3 24b. Wy proped?	Day oute to the cause Probably 4 Vere autopsy find from to completion eath?	✓ Unknown ings available
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Functaral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the burit			Fnd 5:30 ome, farm, stree	and 5:30 am 1 Yes 2 X No subject subjects, farm, street, factory, office building, etc. 28f. Locat				d. Describe hor lbject dr. f. Location (St. Control of Dale) e to the cause	cribe how injury occurred ct drowned in bathtub ation (Street and Number or Rural Route Number, City own State) ale Dr. Overlea, MD e cause(s) and manner as stated.				
(b)		30. Name and address of person w	ho completed cause o	•	,	L			1201				
s	tate	31. Date filed (Month, Day, Year)	32 Regist	rar's Signatu		a eet, bal	unore	, IVIU Z					
Regis	trar	OCT 1 6 2	007	and the	Alpa	w							

DHMH 17 Rev 1/2001 OCME 2006

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2007 Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death
 Month

4b. City, Town, or Location of Death

Year

2007

4c. County of Death

October 13,

12:15 a.M

Physician	
/Medical	
Examiner	

Deborah Ann Hoppe

4a. Facility Name (If not institution, give street and number)

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

Division or Vital Records, P.O. Box 68760, Co To the Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-transit within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending p completely filled in by the funeral director, page 2 should be detached for use as

	13 Walnut Avenu		Overlea				Baltimore						
		Sex 7. Age (In yrs. last birthday) 1 ☐ M 2√2 F Yrs.			If Under 1 Year If Under 24 Hrs. 8. Da Months Days Hours Min. (M			Date of Birth 9. Birthplace (Si (Month, Day, Year) Country)		hplace (State or Foreign buntry)			
	217-60-0339	· · · · · · · · · · · · · · · · · · ·	55	rs.			Jan.	7, 19	52 Ma	ryland			
	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Loca	ation					10d. Inside City Limits			
ŭ	Tob. Oddity		1,000,010,010							1 □Yes 2½ No			
ect	Maryland Baltim	ore	Overl	ea_									
Ē	10e. Street and Number				10f. Zip Code			10g. Citiz	0g. Citizen of What Country?				
rai	13 Walnut Avenu	1			2120	-			United States				
nne	11. Marital Status	nt Ever in U.S. s?	13. W	Was Decedent of Hispanic Origin? (Specify Yes or No- f Yes, specify Cuban, Mexican, Puerto Rican, etc.)				14. Race - American Indian, Black, White, etc.					
Ϋ́Ε	1 Never Married 2 Married	Χνο	1	1 ☐ Yes 2 ☑ No Specify:				Specify: W	hite				
To Be Completed by Funeral Director	3 Widowed 4 Divorced	Year or Dates:		16a Decedent's Havel Occupation									
lete	15. Decedent's E (Specify only highest gr			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)						Industry			
E C	Elementary/Secondary (0-12)	College (1-4or				<i>1)</i>							
ပိ	17. Father's Name (First, Middle, Last	+1		Homemaker 18. Mother's Name (First, Middle, Ma					Own Home				
Be	17.1 date 3 Marile (1 1131, Wildole, Last	,				TO. MOUTET 3 TVA	ine (i nai, imuule	, maiden	Surname)				
은	William Andrew				Doris Elizabeth Hahn g Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)								
	19a. Informant's Name/Relationship	Type. Print)	196.	Mailing	Address (Street	and Number or R	ural Route Numb	er, City o	r Town, State, 2	Zip Code)			
	Stephen Hoppe -	Son	75 Jagb. Place of	36	Berkshir	e Road				nd 21224			
	20a. Method of Disposition 1 ☑ Purial 2 ☐ Cremation 3 ☐	Removal from State	cemetery	, crema	atory or other plac	i	Date	20c. Lo	cation - City or	Town, State			
	4 ☐ Donation 5 ☐ Other (Special	(y) /	HØ1y/R	ede	emer Cem	etery 10)/17/07	Bal	timore	, Maryland			
	21. Signature of theral Service Control 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc.												
	1 / hel	1	ull	7	922 Wise	Avenue	Dunda1	k, Ma	ryland	21222			
	23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between												
Immediate Cause (Final disease or condition										Onset and Death			
	resulting in death)	Due to (or as a consequence of):											
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Der	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consequence of):											
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EX	resulting in death) Last	Due to (or a	is a consequence o	quence of):									
ical		_d											
Jed Jed	IE EEMALE.												
2	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom-	ne pf pregnancy 2 DFetal death	3 □	Ectopic pregnancy	,		2	3d. Date of del	ivery			
Sici	in the past 12 months? 1 ☐ Yes 2 ☑ No		at time of death		Other (specify)				Month	Day Year			
hys	9 Unknown	9L Unknown											
Section Sect										the cause of death?			
be								Yes 2 No 3 Probably 4 Unk					
Completed							24a. Was		24b. Were au	utopsy findings available			
Ë							auto	ormed?	death?	completion of cause of			
ပ္	25. Was case referred to medical					26 Place of Do		2 No	1 □ Yes	2 □ No			
o Be	examiner? 1 ☐ Yes 2 2 No	Hospital:	tient 2 TER/Outs	ationt	3□ DOA Oth	or.	ath (Check only						
Ë	27. Manner of Death	28a. Date of Inj	1 Impatient 2 2 27 Outpatient 3 20A 4 Nursing Home 5 Presidence 6 Other (Specify)										
tio	1 Natural 5 Pending 2 Accident investigation	(Month, D	<i>Day Year)</i> In	ury	28c. Injury at Work? M 1 ☐ Yes 2 ☐ No								
lica	3 Suicide 6 Could not b	De 290 Diggs of Injury. At home form atra						(Street and Number or Rural Route Number,					
erti	4 ☐ Homicide determined		etc. (Specify)	,	,		City or To	wn, State))				
S S	29a. Certifier Certifying Pl	nysician: To the bes	st of my knowledge.	death (occurred at the tir	me, date and place	e, and due to the	cause(s)	and manner as	stated			
Medical Certification: To	(Check only one) 2 Medical Example (Check only one)	miner: On the basis and manners	of examination and	or inve	estigation, in my o	ppinion, death occ	urred at the time	, date and	place, and due	e to the cause(s)			
Se	30h Signature and title of contified				20c Licens			004 D-4					

State Registrar Baltimore, Maryland 21234

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

9512 Harford Road 32. Registrar's Signature

G. Weiner, MD

31. Date filed (Month, Day, Year)

OCT 1 7 2007

Deron Hope Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 07-07987 State of Maryland / Department of Health and Mental Hygiene **UNK UNK** Certificate of Death 1- For State Reg. No 2. Date of Death Decedent's Name (First, Middle,Last) Physician/ Month Day October 13, 2007 0047 hrs Medical Examiner OR 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Baltimore Johns Hopkins Hospital 9. Birthplace (State or 8. Date of Birth(MM/DD/YYYY If Under 1 Year If Under 24Hrs. 6 Sex 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Foreign Days Hours Min Months Country Director 16 1 X M 2 31-7086 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 Yes 2 No narked other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at once. permit Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygeine. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho Director MARYLAND 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA SeKots 21207 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Funeral 11. Mantal Status 12. Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? Never Married 2 Married 2 No Yes TICAN HMERICA 1 Yes 2 7 No specify: Divorced If Yes, Give Year Widowed Š 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Completed Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 Student 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Bethanie HOPE Be Gordon Michael (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Gordon BAHLMORE Clifford Ave. 20c. Location City or Town, State 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition crematory or other place) 1 Burial 2 or other Cremation 3 October 202007 An solowine Donation 5 Other Specify: 22. Name and Address of Facility DANCY M. EUGHACE FUNCAC 3405 W, FRANKIN SHEET. 21-Signature of Funeral Service Licenses W. FRANKLIN SHEET. BATHMORE MARYlAND 21229 elac 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interva Physician Between Onset and Death /Mudical a. Gunshot wounds (two) of head Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of): Examine (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last The law requires that the death certificate be executed Physician/Medical AMENDED UNPENDED ned by the attending physician detached for use as the burial Box 68760, 23d. Date of delivery 23c. If yes, outcome of pregnancy IE FEMALE 23b. Was decedent pregnant in the Year 3 Ectopic pregnancy Month Day Live birth Fetal death past 12 months? Pregnant at time of death Other (Specify) Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. P.O. \$ 1 Yes 2 No 3 Probably 4 Unknown Completed Records, 24b. Were autopsy findings available 24a Was an peen prior to completion of cause of autopsy certificate has performed? death? 2 No ✓ Yes 2 1 🗸 Yes 26.Place of Death (Check only one) To the Hospital or Attending Physician: 25. Was case referred to medica Division of Vital Be Other₄ examiner? Hospital: Nursing Home 5 Residence 6 Other Inpatient 2 V ER/Outpatient 3 DOA After this ိ 1 V Yes 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) FOUND: 28c. Injury at Work? 28b. Time of Injury 27. Manner of Death Certification: Subject shot FOUND: Yes 2 V No Natural Pendina d in by the f Oct 13, 2007 0015 hrs Accident 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. Could not be Suicide or Town, State) 1700 Block of Latrobe Street , Baltimore, MD To the Funeral D (Specify) Local Street 4 V Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

OCMF 2006

DHMH 17 Rev 1/2001

State

29b. Signature and title of certifier

Ana Rubio MD.

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner

Registrar's Signature

29c. License number

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

ORIGINAL

29d. Date signed (Month, Day, Year)

October 13, 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav **Physician** PM^M Anne 2007 Mary Hartman October 10. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Upper Chesapeake Medical Center BelAir Harford If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) . Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours June 7, 216-32-4593 Director 73 1934 New York Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Department of Health and Mental Hygiene. Important; or Items 23a or 28a-f show Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 XNo Director Maryland Harford Joppa 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 219 Chimney Oak Drive 21085 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2000 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 1 ☐ Yes 2 No Specify: þ 3 Widowed 4 Divorced White Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 0/10/07 altimore, Maryland 21215-(Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Drafts Woman Aero Space 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Unknown Unknown ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Warren William Hartman (Husband) 219 Chimney Oak Drive, Joppa, Maryland 21085 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Oct 12 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland Bayview Crematory Inc 2007 21. Sign ture Funeral Service 22. Name and Address of Facility Bruzdzinski Funeral Home, P.A. 1407 Old Eastern Avenue, Essex, Maryland 21221 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician do disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner EVERE ORONARY ARTERY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine DISCASE burial-transit Due to (or as a consequence of): the attending physician hed for use as the burial Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months2 1 ☐ Yes 2 ☐ NO signed by the atte Month 5 Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 entem as been signal 2 should b 1 ☐ Yes 2 No 3 Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy performe 1□ Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 40 1 🗌 Inpatient ဂ္ 1 ☐ Yes 2 R/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Decrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A

Medical 29b. Signature a

16444

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

- 602. S. ATWOOD RD JAY-S NAIRMID

State Registrar

0

31. Date filed (Month, Day, Year)

32 Registrar's Signature OCT 1 7 2007

e of certifier

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 Date of Death
 Month Decedent's Name (First, Middle, Last) Year 2007 Hopper)ctobe 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Wicomico Hospice atthe If Under Year | InUnder 24 Hrs. 8. Date of Birth (Month, Day, Year)
Dec 2, 194 Birthplace (State or Foreign Country) 6. Sex 5. Social Security Number 1 ₹ M 2 □ F Wisconsin 1945 221-28-8032 61 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 ☐ Yes 2 ☑ No MD Salisbury Wicomico 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21801 USA 105 Foxfield Circle #D 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces?
1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 165-71 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Specify: white 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) clerk convience store 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Adeline Olson Ivan Harold Hopper 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 7822 Eileen Drive Salisbury, MD 21801 Patricia A. Petrea/sister 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4□Donation 5\Other (Specify) in state 21. Signature of Funeral Save 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street S. Wade, Director Baltimore, MD 21201

Physician /Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hc Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "naturany injury or other traumatic event, the Medical.

Physician

/Medical

Examiner

Funeral

Director

"natural", or Items 23a or 28a-f show edical Examiner must be notified at

Director

Funeral

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Completed

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

The law requires that the death certificate be executed attending physician and I for use as the burial-trans isigned by the a To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p

Division or Vital Records, P.O. Box 68760,

8	25a. Part 1. Enter the disease, or compleshook, or heart failure. List only of mmediate Cause (Final disease or condition resulting in death)	incations that caused the death. Do not entene cause on each line. a. Due to (or as a insequence of):	er the mode of dying, such as cardiac or	respiratory arrest,	Approximate Interval Between Onset and Death					
xaminer	Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of): Due to (or as a consequence of):								
Completed by Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Year					
ompleted by Ph	Part II. Other significant conditions con Coronary C Cushings Diabetics	ontributing to death but not resulting in the un Ortery Dige Disease Mollitus: Tupo	nderlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 □ Yes 2 □ No 3 □ Probably 4 ■ Unknown 24a. Was an autopsy performed? prior to completion of cause of death? 1 □ Yes 2 ■ No 1 □ Yes 2 ■ No						
Be	25. Was case referred to medical examiner?	6 StOther (Specify) Hospice								
Certification: To	1 Yes 2 No 27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined		f 28c. Injury at Work? M 1 □ Yes 2 □ No	28d. Describe how in	w injury occurred reet and Number or Rural Route Number,					
Medical (29a. Certifier 1. ☐ Certifying Phy (Check only one) 2 ☐ Medical Exam	ysician: To the best of my knowledge, death niner: On the basis of examination and/or in and manner stated.	vestigation, in my opinion, death occurr	ed at the time, date a	and place, and due to the cause(s)					
⋝	29b. Signature and title of certifier		29c. License number	29d. [Date signed (Month, Day, Year)					

State Registrar 31. Date filed (Month, Day, Year) 2007

29b. Signature and title of certifier

32. Registrar's Signature

Name and address of person who completed cause of death (Item 23a) (Type, Print)

GREGORIO M. BELLOSO, M.D.: 5302 CHINABERRY DR., SALISBURY MD 21801

29505

10-14-07

			1-	For State Registrar		State of M	iarylan			nt of He te of D		vientai H	ygien Reg. N	2001	33	3253
	Dhusisi	0.00	1. D	ecedent's Name (First	t, Middle, La	st)						2. Date of Month		ay Year	3. Tim	e of Death
	Physici /Medic			Richard C.								Octobe	er 4,	2007		3 AM M
	Examin	er	4a. I	Facility Name (If not in	_		r)		4b. City		ocation of Death	1	4	tc. County of Deat		
			5. S	26 Bella V ocial Security Number			ge (In vrs.	last birthday)	tf Und		ninster If Under 24 Hrs.	8. Date of I	Birth	Carroll		ite or Foreign
ь	Funeral Director			13-40-1633		1 ∑ M 2□F	66	Yrs.	Months	Days	Hours Min.	8. Date of I (Month, Sept 2	Day, Yea !1 , 1	941 Mar	yland	
	pu .		Usu	al Residence of Dece	dent County		10c Cit	y, Town or Lo	cation						10d Insid	e City Limits
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	r 28a-	Funeral Director	10e.	. Street and Number						ip Code			10g. 0	Citizen of What Co	untry?	
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	r dea	Iner	11.	Marital Status		12. Was Deceden Armed Forces		.S. 13.	Was Dec f Yes, sp	edent of His	panic Origin? (S , Mexican, Puert	pecify Yes or o Rican, etc.)	No-	14. Race - Ame Black, White		٦,
36	be filed within 72 hours after death with the Maryland that Hygiene. of other than "natural", or iteme 23a or 28a-f ahow event, I're Madical Examinar must be notified at	by F		1 ☐ Never Married 2 3 ☐ Widowed 4 🗓 D	_	1 XYes 2 If Yes, Give Year or Dates		63	1 🗆 Yes	2 ∑ No	Specify:			Specify: wh	ite	
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Maryland	S should be filed withir and Mental Hygiene. is marked other than eumatic event, Ire M	9 Be	17.	Carvel Au										e Wheele	r	
ary	s 1 and 2 should if Health and Men item 27 is marke other treumatic	To	19a	. Informant's Name/Re				19b. Mailir	ng Addre	ss (Street a				y or Town, State, 2		
	27 mg		E	Emma Rill/s	sister			26 B	e11_	Vita	Westmin	ster, l	MD 2	1157		
ore	of He of He If item or oth			. Method of Disposition 1 ☐ Buriat 2 ☐ Crer		Removal from State		lace of Dispo emetery, crea	sition (N. natory or	ame of other place)	Date	20c.	Location - City or	Town, State	9
Baltimore,	permit. Pages 1 ar Department of Hea Importent: If item any injury or othe			4 ☑Donation 5 ☐C	ther (Specia	(y)										
Bal	permit. Departrimporte		21.	Signature of Funeral Rona	Id S.	Wade, Dir	rector	: 8	tate	Anat More.		655 201	W. B	altimore	Stre	et
			23	. Part 1. Enter the dise shock, of heart failu	ease, or com	plications that cause one cause on each	ed the deat						arrest,		Approxi Interval	Between
)	Physician		dise	nediate Cause (Final ease or condition ulting in death)		a Ac	ure	My	oCa	rdia	1 int	arcn	0 ^		Hou	nd Death
	/Medical Examiner		103	unisig in death)	(Due to (or a	s a conseq	uence of):		~~~	d	5000	2		5	
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of Vital Records,	uires t signe	d by						g	,,	g			Yes			Donknown
00	s been si	Completed										24a. W		24b. Were au	topsy findir	ngs available
Re	The lav	E O										au pe 1 □ Yes	topsy rformed? 2 121	death?	completion 2 No	of cause of
/ital		Bec		Was case referred to examiner?	medicat						26. Place of Dea					
of \	Ø .∞ ₹	မ		1 ☐ Yes 2 € No		Hospital: 1 Inpat		ER/Outpatier			4 Nursing r			6 Other (Specially occurred	city)	
	ding th. After funer	tion		Manner of Death 1 ■ Natural 5 □ 2 □ Accident	Pending investigatio	28a. Date of In (Month, D	lay Year)	28b. Time o Injury	м	28c. Injury Work 1 □ Y	at ? es 2 □ No	28d. Descrit	ie now in	qury occurred		
Division	Attending or death.	Certification:			Could not be	28e. Place of I			eet, facto	ry, office		28f. Location	(Street Town, Sta	and Number or Ru	iral Route I	Number,
	rs after or all Dir	Cert			,		etc. (Specif									
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical	298	a. Certifier 120 (Check only 2 N	Certifying Place Medical Exa	hysician: To the bes miner: On the basis and manner:	of examina	wledge, deat ition and/or in	occurre vestigation	d at the time on, in my op	e, date and place inion, death occu	, and due to the irred at the tim	ne cause e, date a	(s) and manner as and place, and due	stated. to the cau	se(s)
	within To the	Me	29b	. Signature and title of	certifier	2/	0/		2	9c. License	number		29d. [Date signed (Mont	h, Day, Yea	ar)
				Cum	HHel	ky nD.	Phy	SIFIA	2	Do	3338	8		10/10/0	7	
			30.	Name and address of	person who		death (Item	n 23a) (Type,	Print)				15	MINSTER		21157
	Sta	to	31.	Date filed (Month, Day	y, Year)		trar's Signa		2	יישר	VC /	r , 00	121.	7777	שא	/ (110
	Registr			OCT 1	7 2007	Jak Millian	150	Jan 1								

DHMH 17 Rev 1/2001

Registrar

Robert lee Johns Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene UNK UNK Certificate of Death 1- For State Rea, No Registrar 2 Date of Death . Decedent's Name (First, Middle.Last) Physician/ Month Day October 12, 2007 1130 hrs **Medical Examiner** Johns Lee Robert 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Baltimore County** Owings Mills In front of 11422 Reisterstown Road If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year 7. Age (In vrs. last birthday) 5. Social Security Number **Funeral** Foreign Davs Hours Months Country) Director MD 36 03 1 X M 2 81 219-10-4221 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State Yes 2x No Pikesville Baltimore MD permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified as now. Director 10g. Citizen of What Country? 10e. Street and Number 21208 Pomona West #10 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Funeral Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White etc. Armed Forces? 1 Never Married 2 Married X Yes Black Specify: If Yes, Give Year or Dates: 1 Yes 🗶 No specify: 4 X Divorced Widowed Š b. Kind of Business/Industry atuxent Halfway 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed Elementary/Secondary (0-12) College (1-4 or 5+) Asst. Superintendent House 12th grade 6yrs 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Goldie Eulalia Wilson Be Robert Lee Johns Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Durum Ct., Owings Mills, Md 21117 Joni Johns Williams-Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition Baltimore, crematory or other place) Removal from State Burial 2X Cremation 3 10/16/07 Baltimore, Md Metro Crematory In¢ Nonation 5 Other Specify: 22.Name and Address of Facility March F/H West 4300 Wabash Ave, 21. ig ture of Funeral Service Licensee Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval **Physician** Between Onset and Death rM dical a. Multiple Injuries Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause Examiner (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last the Hospital or Attending Physician: The law requires that the death certificate be executed and Physician/Medical UNPENDED **AMENDED** physician the burial -Box 68760, 23d, Date of delivery 23c. If ves. outcome of pregnancy IF FEMALE: 23b. Was decedent pregnant in the Year 3 Ectopic pregnancy Day Live birth Fetal death 2 past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 No 9 Unknown has been signed by the att 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. o. 1 Yes 2 V No 3 Probably 4 Unknown ģ σ. Completed 24b. Were autopsy findings available Records, 24a. Was an prior to completion of cause of autopsy this certificate has be Il director, page 2 sho performed? death? 2 No ✓ Yes 2 No 1 🗸 Yes 26. Place of Death (Check only one) 25. Was case referred to medical Division of Vital Be examiner? Hospital: Other; Residence 6 V Other: Scene Nursing Home 5 DOA Inpatient 2 FR/Outpatient 3 this 2 1 🗸 Yes 2 No 28d. Describe how injury occurred After the 28a. Date of Injury (Month, Day, Year) FOUND: 28c. Injury at Work? 28b. Time of Injury 27. Manner of Death Driver of car struck parked truck Certification: FOUND: 1 Yes 2 V No Natural 5 Pending

State Registrar

ORIGINAL

1130 hrs

(Specify) Major Road / Highway

28e. Place of Injury - At home, farm, street, factory, office building, etc

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c, License number

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

Oct 12, 2007

and manner stated

Assistant Medical Examiner

32. Registrar's Signature

Investigation

Could not be

30. Name and address of person who completed cause of death (Item 23a)

2007

28f. Location (Street and Number or Rural Route Number, City

or Town, State) In front of 11422 Reisterstown Road, Owings Mills, MD

October 13, 2007

29d. Date signed (Month, Day, Year)

24 hours after death. To the Funeral Director: completely filled in by the

2 🗸 Accident

29a. Certifier 1

Suicide

Homicide

29b. Signature and title of certifier

Myrite

Margarita Korell MD.

31. Date filed (Month, Day, Year)

3

one)

Medical

		1	For State Registrar	State of M	laryland	-	ertment o				iene 0	07	33255
3	Physici	20	1. Decedent's Name (First, Middle,			T C C				2. Date of Dea Month	Day	Year	3. Time of Death
	/Medic		Betty	Clarice		Jeffe			(D)	Octobe	er 14,		2:55P M
	Examir	er	4a. Facility Name (If not institution,		7)			n, or Location ninster			Carr		
	Financi		Carroll Hospita 5. Social Security Number 6		ge (In yrs. Ia	ast birthday)	If Under 1 Y	ear If Under	r 24 Hrs.	8. Date of Birth	1	9. Birthp	place (State or Foreign
	Funeral Director		212-28-6580	1□M 2 ⊠ F	84	Yrs.	Months Da	ys Hours	Min.	(Month, Day lug. 25		Eng.	
100	p		Usual Residence of Decedent 10a. State 10b. County		10c City	, Town or Lo	cation						Od. Inside City Limits
	sho	5					oution.						1 ☐ Yes 2 🕅 No
	28a-1	rect	MD Balti 10e. Street and Number	more	паш	oden	10f. Zip Cod	de		1	0g. Citizen of	What Cou	ntry?
	3a or	0	1119 Rolling He	eights Aven	ue			21211			U.S	.A.	
	deat	Funeral Director	11. Marital Status	12. Was Deceden Armed Forces	t Ever in U.S	3. 13.	Was Decedent	of Hispanic O Cuban, Mexica	rigin? (Spec	ofy Yes or No- lican, etc.)	14. Ra Bla	ce - America	
36	or Its	by Fu	1 Never Married 2 Married	d 1 ☐ Yes 2 🔀 If Yes, Give	No		I□Yes 2 K			, , ,		^{fy:} Whi	
00	72 hours after death with the Maryland natural', or Itama 23a or 28a-f show orcal Exeminat must be redified at	q pe	3 ☑ Widowed 4 ☐ Divorced 15. Decedent's	Year or Dates	:	16a Deced	dent's Usual O	cupation			16b. Kind of E		
7	in 72 n "nai	plete	(Specify only highest	grade completed)	- F	(Give	kind of work di DO NOT use re	one durina mo	st of workin	g			
212	e filed within al Hygiene. I other than "	Completed	Elementary/Secondary (0-12)	College (1-4or	5+)	Во	okkeep	er			Groce	ry St	ore
pu		BeC	17. Father's Name (First, Middle, La							(First, Middle,		me)	
yla	2 should be and Mental Is marked o	2	Edward Charles							Manning		- T	0 ()
Maryland 21215-0036	12 sh h and 7 Is m traum		19a. Informant's Name/Relationship	_						Route Number			Code)
e,	es 1 and 2 should b of Health and Menti f Item 27 is marked ir other traumatic a		Erma Gill 20a. Method of Disposition	Niece	20b. Pf	ace of Dispo	sition (Name o	f		ate	20c. Location		own, State
Baltimore,	permit. Pages 1 Department of H Importent: If Ite any In ury or ot		1 ☑ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe				natory or other Park Ce		10-18	3-07	Wood1a	awn,	MD
alti	mit. F partme sortar Injur		21. Signature of Funeral Service to		<u></u>		. Name and A			-	Reiste	rstov	m Road
m	Depa Impo any lo		· TEM	Mai	mi	E	LINE F	UNERAL	HOME	Reist	erstown	, MD	21136
1-4-3	Physician /Medical Examiner		23a. Part1. Enter the disease, or conshock, or heart failure. List or immediate Cause (Final disease or condition resulting in death)	aa	ed the death line. Solution	40	er the mode of	dying, such a	s cardiac or	respiratory ari	rest,		Approximate Interval Between Onset and Death
8760,	be executed icien and burial-transit	Ical Examiner	Sequentially list conditions, if any, leading to him adiate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	is a consequ								
9	tificat ng phy as the												
.O. Box	it the death certificate by the attending phys tached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcom 1□Live birth 4□Pregnant 9□Unknown	2 Fetal at time of de	death 3	Ectopic pregn Other (specif					ate of deliv	ery Day Year
Δ.	es the igned be de	þ	Part II. Other significant condition	s contributing to death	but not resu	ulting in the u	nderlying caus	e given in Part	t 1.	23e. Did to	_/		the cause of death?
Records,	The taw requir sate has been si page 2 should	Completed								24a. Was autop	med?	prior to co death?	opsy findings available ompletion of cause of
Vitai	an; T tificat tor, pa	0	25. Was case referred to medical					26. Plac	ce of Death	1 ☐ Yes (Check only o	No No	1 🗆 Yes	20 100
Ž	ysici is cer direc	To B	examiner? 1 Yes 2 No	Hospital:	tient 2 1	ER/Outpatier	nt 3 DOA	Other: 4 🗆 N	Nursing Hon	ne 5 Resid	lence 6 🗆 O	ther (Speci	fy)
ion of	19 E		27. Manner of Death 1 Natural 5 Pending 2 Accident investiga			28b. Time o Injury	f 28c.	Injury at Work? 1 Yes 2		8d. Describe h	now injury occu	ırred	
Division	≥ = = -	Certification:	3 Suicide 6 Could no 4 Homicide determin	286. Place of I	njury - At ho etc. (Specify	me, farm, st	reet, factory, of	fice	2	28f. Location (5 City or Tow		iber or Rur	al Route Number,
	To the Hospitel c within 24 hours af To the Funeral D completely filled in	Medical		Physician To the best xaminer: On the basis and manner	of examinat								
	withir To th	Ž	29b. Signature and title of tertifier		No	ML	,	cense number			29d. Date sign	ed (Month	Day, Year)
	A 1		Mal	C. M	1	===	1	W5 9'S	52		10/	17/0	
	17		30. Name and address of person w	no completed cause of	f death (Item	23a) (Type,	Print)	1000		Spn/~	0000	00 1)	3115-53
	e establishes	ate	31. Date filed (Month, Day, Year)	32 Regis	strar's Signal		T PCCI	e 160	cue.	0/17/10	1114	1110	21157
*1	Regist			2007 8	are de	X Lo	2000						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrer Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Yeer OHNSON **Physician** MF 00-7 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner SSU KEGIONAL RUNDALE HOSPIVK Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 6 Sex Birthplace (State or Foreign Country) 8. Date of Birth 5. Social Security Number **Funeral** Hours Min Months Days 10M 20F 213-62-8250 Usual Residence of Decedent Yrs Director the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County item 27 is marked other than "natural", or Items 23e or 28e-f show other traumatic event, the Medical Examinar must be notified at 1 1 10 2 1 No Director MD Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code US A Fremont Avenue 133a alali by Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Baltimore, Maryland 21215-0036 Black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within in Department of Health and Mental Hygiene Important: if Item 27 is marked other than "reany injury or other traumatic avant Elementary/Secondary (0-12) College (1-4or 5+) 4yrs Hinter Factoru 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Young James L Helen L. Johnson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Sonia L. Johnson / sister 1332 N. Fremont Ave. Baltimore, MD 21217 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 10.17.2007 4 ☐ Donation 5 ☐ Other (Specify) Baltimore mD Arbutus Memorial 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Compassion Funeral Services MO1363 119-121 S. Stricker St Baltimore, MD 21223 Approximate Interval Between Onset and Death 23a. Part T. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner ed by the attending physician and detached for use as the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 ANCER Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 Tyes Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 2 No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 1 Inpatient 2 1 Yes 2 🔲 No 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death 28b. Time of To the Hospital or Attending F within 24 hours after death. To the Funeral Director: After t Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 🗌 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medicai 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number

State Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

1

MOT

DHMH 17 Rev 1/2001

3 Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

10

DRI

GATEWA

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. burial-tran the attending p been signed by the should be detached cate has t certificate director, this After Director: within 24 hours after To the Funeral Di completely filled in the 2

Division or Vital Records, P.O. Box 68760, ${\mathcal L}_{\mathcal L}$

October 15 2007 2007 10:00P /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Baltimore County 205 Elinor Avenue If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. March Day 9247 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Baltimore, Maryland 1 □ M 2 🖵 F 218 14 1685 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show 1 ☐ Yes 2 ☑ No Baltimore Baltimore County Director Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number a or 21236 USA 205 Elinor Avenue 23a permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a any Injury or other traumatic event, the Medical Examiner must! Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2√☐ No Specify. If Yes, Give Year or Dates: Specify: þ White 3 Widowed 4 □ Divorced 16b. Kind of Business/Industry Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Housekeeping-Own Home N/A Homemaker 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Grace Helen Conklin William Frederick Schwarz 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 110 Springside Drive Timonium, Md. 21093 Sherry L Grabus (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State October 19 2007 Baltimore, Maryland Gardens of Faith Cem. 4 □ Donation 5 □ Other (Specify) 21. Signat e of Funeral Service Li ensee 22. Name and Address of Facility

Lassahn Funeral Home Inc 7401 Belair Road Baltimore, Maryland 21236 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final MYOCARDIAL INFARCTION MINUTES disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to him editing cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Month in the past 12 months? 1 ☐ Yes 2 ■ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform 1 ☐ Yes 2 ☐ No 2 No 26. Place of Death Check onl one 25. Was case referred to medical examiner? Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 No 2 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Medical Certification: Injury 1 MNatural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 Homicide determined 🕊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier Zerrom D40480 OCTOBER 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21236 FERRO, MD FERNANDO 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

	Amend #5 Per FH C872 1 Amend #16b Per FH 1. Decedent's Name (First, Middle, Las	On tate of Maryland / De	epartment of Hea Certificate of De	4	neg. No.	33258
Physician	/1	Kous		2. Dete of De Month	Day Yea	3. Time of Death
/Medical	4a Fecility Neme (If not institution, give	treet end number)	4b. C	ity, Town, or Location of Deal	13	path
Funeral Director	FU+U/E (A/E - 6.5) 5. Social Security Number 6. Sec. 217 68 0005 11	CHARLES VILLA	Months Davs H	Jnder 24 Hrs. 8. Date of Bi Jours Min. Month, D	rith Yeer) 9. B	irthplace (State or Foreign Country)
and	Usuel Residence of Decedent 10a. State 10b. County	10c. City, Town o	or Location			10d. Inside City Limits
h the Marylar r 28a-f show notified at	mA	BAl+i	MOLE			1 A Yes 2 □ No
with the M 3a or 28a-f If be notified	10e. Street end Number	I Au. Rd	10f. Zip Code	9	10g. Citizen of What	Country?
d 21215-0020 filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 28a-1 show not, the Medical Examiner must be notified at a Completed by Funeral Director	11. Maritel Status Never Married 2XXMarried	1 ☐ Yes 2 No If Yes, Give	· ·	nic Origin? (Specify Yes or Nexican, Puerto Rican, etc.)	o- 14. Raca - Ar Black, W Specify: 2	merican Indian, hite, etc.
ind 21215-0020 be filed within 72 hours at tal Hygiene. I other than "natural", or event, the Medical Exam event, the Medical Exam Be Completed by B	3 ☐ Widowed 4 ☐ Divorcad 15. Decedent's Ed	Year or Detes:	ecadent's Usual Occupation		16b. Kind of Busines	ss/Industry
215.	(Specify only highest green Elementary/Secondary (0-12)	de completed) ((Give kind of work done durin ife. DO NOT use retired)	g most of working	Depart	ment of
d 211, Higher the other the ent, the	10	C ,		HIMOVE Mother's Name (First, Middle	Sanita Maiden Surgama	tion
ire, Maryland 212 s 1 and 2 should be filled within t Health and Mental Hygiene. them 27 is marked other than other traumatic event, the M To Be Comp	17. Father's Name (First, Middle, Last) A A YON TE	y.S		USIE MA	y MAY	tin
Tary 2 shou and N is mer	19a. Informant's Name/Relationship	pe, Print) 5.5 + E/ 19b. N	Mailing Address (Street and	Number or Rurel Route Num	20. 1	e, Zip Code)
≥ 5 = 7 ±	JEAN JOH J 20a. Method of Disposition	V301 13 J	Disposition (Name of	(d BAITIMO	20c. Location - City	or Town, State
nor ages ant of lattiffee	1 Surial 2 Cremation 3 ☐ 4 Donation 5 Other (Specify	Removal from State	crematory or other place)	1420107	LANSDOU	NE MO
Baltimore, parmit. Pages 1 at Department of Hee Important: if them any injury or othe once.	21. Signature of Funeral Service Licen			Facility Phillip A	1 WEATHEI	OFA F.S P.A.
	23a Perti Enter he disease or come	Olications hat caused the death. Do no	at enter the mode of dving, so	IVERST BA	arrest,	Approximate
Physician /Medical	Immediate Cause (Final	one cause on each line.	ommon Common			Interval Between Onset and Death
Examiner	disease or condition resulting in death)	Due to (or as a co	onsequence of):	era -		
sit sit		b	J			1
58760,	Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last	Due to (or as a co				
		d				
Box leath cert attandin d for use	Part II. Other eignificent conditions of	ontributing to death but not resulting in t	the underlying cause given in	Part I. 23b. Die	d tobacco use contrib	ute to the cause of death?
P.O. hat the code by the datachec	Part II. Other significent conditions to	officialing to death out not resulting and	into underlying educe given in			Probably 4 Nunknown
Division of Vital Records, P.O. Box 6 To the Hoepital or Attanding Physician: The law requiras that tha death certifi within 24 hours after death. To the Funeral Director: After this certificata has been signed by the attanding completely filled in by tha funaral director, page 2 should be datached for use as Medical Certification: To Be Completed by Physician/Me					as an autopsy 24 formed?	b. Were autopsy findings available prior to completion of cause of death?
I Re				10	Yes 23No	1 ☐ Yes 🔀 No
/ita	25. Was case referred to medical examiner?	No or Male	Othor	. Place of Death (Check only		
Of \Physic Physic ral dire : To	1 Yes 2 No		Datient 3LJ DOA	A Nursing Home 5 ☐ Re 28d. Describe	sidence 6 Other (S e how injury occurred	Specify)
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or Attender dear or Attender dear or Attender dear in by the ertifice	3 ☐ Suicide 6 ☐ Could not be determined	28e. Placa of Injury - At home, farm building, etc. (Specify)	m, street, factory, offica	28f. Location City or T	(Street and Number o own, State)	r Rurel Route Number,
Division of V the Hospital or Attanding Physic thin 24 hours after death. the Funeral Director: After this or empletely filled in by the funeral dire Medical Certification: To	29a. Certifier (Check only one) Certifying Ph	ysiclan: To the best of my knowledge, niner: On the basis of examination end- end manner stated.	death occurred at the time, of or investigation, in my opinion	date and place, and due to the on, death occurred at the time	e cause(s) and manne e, date and place, and	r as stated. due to the cause(s)
To the within To the compl	29b. Signature and title of cartifier		29c. License nu		29d. Date signed (M	
	1 skamped) MD, FACP	D	57088	UCTOBER	17,2007
	30. Name end eddress of person who 7how Row	completed cause of death (Item 23a) (T	Paul Street	57088 , Bashimou	, MD 21	202
State Registrar	31. Date filed (Month, Day, Year)	32. Ragistrar's Signature	ball			

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Lest) Dey Month **Physician** October 14, 2007 13:40 PM Mary Corinne Lynch /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Neme (If not institution, give street and number) Examiner Montgomery Rockville Hebrew Home of Greater Washington 9. Birthplace (State or Foreign Country) New York If Under 24 Hrs. Hours Min. If Under 1 Year 8. Date of Birth (Month, Dey, Year) 7. Age (In yrs. lest birthday) 5. Social Security Number **Funeral** Days Months 1 ☐ M 2 🖾 F 75 November 16, 1931 062-26-7818 Director Usual Residence of Decedent 10d. Inside City Limits with the Merylenc 10c. City, Town or Location 10a. State 10b. County r than "naturel", or items 23a or 28e-f ehov the Medical Examiner must be notified at 1 ∏ Yes 217 No Directo Potomac Maryland Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20854 United States 11717 Gregerscroft Road Funeral Pages 1 end 2 should be filed within 72 hours efter death nent of Health end Mental Hygiene. 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 No Specify: Specify: White ò 3 Widowed 4 Divorced Be Completed 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) College (1-4or 5+) 5+ h end Mental Hygiene. Elementary/Secondary (0-12) Librarian Library 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) John J. Herk Marian Purcell 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) Depertment of Health er Important: If Item 27 is any injury or other trau Thomas J. Lynch / Husband 11717 Gregerscroft Road, Potomac, Maryland 20854 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition October 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 16,2007 Bethesda, Maryland Pumphrey Funeral Home/ Montgomery Avenue, -2805 4 ☐ Donation 5 ☐ Other (Specify) Montgomery Crematorium, Inc. 22. Name and Address of Facility Robert A. Rockville, Inc., 300 West Rockville, Maryland 20850 21. Signature of Funeral Service Licenses M01473 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** 15 min Immediate Cause (Final disease or condition resulting in death) MYOCARDIAL INFARCTION /Medical Examiner edical Certification: To Be Completed by Physician/Medical Examiner CO ROMARY Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initieted events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): th?

Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760. vurs efter deeth. eral Director: After this certificate hes been signed l filled in by the funeral director, page 2 should be del

Baltimore, Maryland 21215-0020

rt II. Other significant conditions co	entributing to death but not res	sulting in the underlying	cause given in Part I.	23b. Did tobecco use co 1 □ Yes 2 및 No	ntribute to the cause of dea
				24a. Was an autopsy performed?	24b. Were autopsy finding available prior to completion of cause of death? 1 □ Yes 2 □ No
. Was case referred to medical examiner?				eath (Check only one)	
1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3 D	OOA Other: 4 Nursing	Home 5 ☐ Residence 6 ☐ Oth	ner (Specify)
. Menne of Death 1 Matural 5 ☐ Pending 2 ☐ Accident investigation	28e. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury et Work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury occur	rred
3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At h building, etc. (Special	ome, farm, street, facto	ry, office	28f. Location (Street and Numb City or Town, State)	ber or Rural Route Number,

To the Hospital within 24 hours e To the Funeral Completely filled

State

MD

7 2007

29b. Signature and title of certifie

29d. Date signed (Month, Day, Year)

Rd ROCKVILLE MD

completed cause of death (Item 23a) (Type, Print) 30. Name and address of ≠

MPTON MO 6121

32. Registrar's Signature

31. Dete filed (Month, Day, Year) Hegistrar

			1- State of Maryland / Registrar	Department of Health and MacCertificate of Death	ental Hygiei Reg.	71111 337h
ľ	Physicia	an	1. Decedent's Name (First, Middle, Last) George Richard Leiben		Date of Death Month	Day Year 7:20 pM
	/Medic	_	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death
-	Funeral Director		Forest Haven Nursing Home 5. Social Security Number 6. Sex 1 $\stackrel{\text{Nursing}}{\square}$ 7. Age (In yrs. last to $13-30-7341$	Baltimore birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Ye 1 – 7 – 193	Baltimore 9. Birthplace (State or Foreign Country) Maryland
	aryland show dat			wn or Location		10d. Inside City Limits 1
	with the Ma a or 28a-f	Funeral Director	MD Anne Arundel Pasac	10f. Zip Code 21122	-	Citizen of What Country?
36	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. If Health and Mental Hygiene. A 1st marked other than "natural" or items 23a or 28a-f show other traumatic event, the Mental Examiner must be notified at	by Funera	11. Marital Status 1 □ Never Married 2 Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ▼ No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto t 1 ☐ Yes 2 ₹ No Specify:		14. Race - American Indian, Black, White, etc. Specify: White
21215-0036	nin 72 hou In "natura Modical E	Completed by	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	a. Decedent's Usual Occupation (Give kind of work done during most of workir life. DO NOT use retired)	ng 16b	. Kind of Business/Industry
212	filed within Hygiene. Ither than "		12 years n/a 1	Pipefitter	F (First, Middle, Maid	MC Corp.
land	ld be filental H ked otl ic ever	To Be	17. Father's Name (First, Middle, Last) Francis Leiben			a Benser
Maryland	12 should be filed within h and Mental Hygiene. 7 Is marked other than "traumatic event, the Meg		1 1 2	9b. Mailing Address (Street and Number or Rura		
	ges 1 and 2 t of Health If Item 27 I or other tra		20a. Method of Disposition 20b. Place	d Disposition (Name of tery, crematory or other place)		a, MD Z11ZZ Location - City or Town, State
Baltimore,	t. Page rtment o rtant: If			view Crematory $10-1$		
Ba	Depared Important Importan		J. Wayne Osterling	Funera L. Pasad	1 Home, P.A. ena, MD 21122	
2	Physician /Medical Examiner	S1 1	Display the disease, or complications that caused the death. Display the interest of the complex transfer of the complex trans	onot enter the mode of dying, such as cardiac of RoTL CLRLBRO VA	or respiratory arrest,	Approximate Interval Between
68760, 💉	ficate be executed physician and is the burial-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of the consequen			
P.O. Box 6	the death certi yy the attending ached for use a	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death			23d. Date of delivery Month Day Year
	aw requires that s been signed b ? should be deta	þ	Part II. Other significant conditions contributing to death but not resulting	in the underlying cause given in Part I.		co use contribute to the cause of death? 2 ☐ No 3 ☐ Probably 4 ☐ ☐ ☐ Known
or Vital Records,	The ate h page	Completed			24a. Was an autopsy performed	24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2☑No
Vita	ysician: The is certificate hadirector, page	Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/0	26. Place of Death		o Flori (0 / 1)
on or	To the Hospital or Attending Physician: within 24 hours after deals. To the Funeral Director: After this certificacompletely filled in by the funeral director,	tion: To	To res 25 No	Dutpatient 3 DOA 4 Nursing Hor	me 5 L Residence 28d. Describe how i	e 6 □Other (<i>Specify</i>) njury occurred
Division	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of injury - At home, building, etc. (Specify)	farm, street, factory, office	28f. Location (Stree City or Town, S	t and Number or Rural Route Number, tate)
	To the Hospita within 24 hours To the Funeral completely filled	Medical C	29a. Certifier (Check only one) Certifying Physician: To the best of my knowled and manner stated.	ge, death occurred at the time, date and place, and/or investigation, in my opinion, death occurr	and due to the caus red at the time, date	e(s) and manner as stated. and place, and due to the cause(s)
	To the vithin To the comp	Me	29b. Signature and title of certifier	29c. License number	29d.	Date signed (Month, Day, Year)
	10	,	30. Name and address of person who completed cause of death (Item 23a	1) (Type, Print)	Part :	10/1707
	Sta	te.	31. Date filed (Month, Day, Year) & Registrar's Signature	HOIVE SUITE 203,	MACIO	IVIN HIE I
	Registr		DET 1 7 2007 AS	E COME		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Transferred to the control of the co				1- State of Maryland / Department of Health and M Certificate of Death	lental Hyg R	eg. No 2007	33262
Fruntier Frunti	ed in pac	Physicia	an		Month	Day Year	
Security Number Security N				4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death	SEFIEM BE	4c. County of Deat	h
The state of the s					8 Date of Birth		
150 State 150 County 150 State 150 St				NONE 1 M 2 F Yrs. Months Days Hours Min.	(Month, Day	, Year) Co	
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Secretary 2 Committee 3 Chemoster 4 December 4 D	, Mo	and 2 :sealth al		Michael + Vilma MEEHAN (PARENTS) 9202 OSWALD WAY ROSEDA	IE, MARY	land 21237	Apt. 10
Physician Medical Examiner 23a. Part I. Einer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate fictive visible was an autopsy or great and the control of the standard events. Bequentially list conditions. Cause (Disease or Injury Sequentially list or Injury Sequentially list or Injury Sequentially list or Injury Sequentially list or Injury Sequentially list or Injury Sequentially list or Injury Sequentially list or Injury Sequential list or Injury Sequential list or Injury Sequential list or Injury Sequential list or Injury Sequential list or Injury Sequential list or Injury Sequential list or Injury Seq	ב ב	0 0 - -		Debunal 2 Gremation 3 Hernoval from State	Ember	,	
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Physician Medical Examiner Physician Medical Examiner Physician Medical Examiner Physician Ph	ă	any per					
Due to (or as a consequence of): Sequentially list conditions, list conditions, list, resulting in death) Due to (or as a consequence of):				shock, or heart failure. List only one cause on each line.	or respiratory arr	rest,	Interval Between
Sequentially list conditions: Sequentially list conditions are consequence of				disease or condition a. In Evitable 100 HBD			5 days
Second S		Examiner	_	Sequentially list conditions, b. Preng tunty		A 980	64 min.
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25. Was case referred to medical examiner? 1	000	ificate I g physical as the t	edica	d	r	1	* * *
25. Was case referred to medical examiner? 1	YOG .	death cert a attending d for use a	ician/M	23b. Was decedent pregnant in the past 12 months? 1 □ Live birth 2 □ Fetal death 12 □ Fetal death 13 □ Ectopic pregnancy 1 □ Live birth 2 □ Fetal death 15 □ Other (specify) □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □			
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101 Con h 4 Sw nos D57561 9/23/2007		ne Hos n 24 hc ne Fun pletely	edica	(Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occur			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) State Registrar 31. Date filed (Month, Day, Year) 32. Registrar's Signature OCT 1 7 2007		To t To tl	M	200.009.11111	1		
State Registrar 31. Date filed (Month, Day, Year) OCT 1 7 2007 State Registrar OCT 1 7 2007	./	2.H		30. Name and address of person who completed cause of death (Item 23a) (Type. Print)	7200 40	nov R- 1	12007
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				31. Date filed (Month, Day, Year) OCT 1 7 2007 32. Registrar's Signature		-	

DHMH 17 Rev 1/2001

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 33263 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2, Date of Death Month **Physician** Melton ernon House October 2007 2:54 16 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner N Baltimope University of Maryland Medical Centur If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign XXM 2□F Months Days Hours 77 238-36-1979 2, 1929 North Carolina Nov. Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County 1 ☐ Yes 2\\ No Directo Maryland Baltimore Upperco 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code United States 5012 Frye Road 21155 Funeral America of 12. Was Decedent Ever in U.S. Armed Forces? 1948— Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status Y∑Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married ※ Married 1953 1 ☐ Yes 🏋 No Specify: Specify: White 9 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) 12th College (1-4or 5+) Mechanic Schmidt Baking Co. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Everette Melton Mattie Causey 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Elizabeth May Melton (Wife) 5012 Frye Road, Upperco, Maryland 21155 20b. Place of Disposition (Name of cemetery crematory or other place)
Dover United Methodist 20a. Method of Disposition 20c. Location - City or Town, State 1XXBurial 2 ☐ Cremation 3 ☐ Removal from State Oct. 19, 4 □ Donation 5 □ Other (Specify) Church Cemetery Reisterstown, Maryland 21. Signature of Funeral Service License 22. Name and Address of Facility Eckhardt Funeral Chapel, P.A. 3296 Charmil Drive, Manchester, Maryland 21102 Foler the disease, or com wations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pheumonia WKS disease or condition resulting in death) Due to (or as a consequence of): unknown COPD Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of): Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9∏Unknown 9 Unknown ဥ Certification:

permit. Pages 1 and 2 should be filed within 72 hours after dear Department of Health and Mental Hygiene. Important: If item 27 is marked other the any injury or other trainments. **Physician** /Medical **Examiner** physician and s the burial-transit Division or Vital Records, P.O. Box 68760, C.

Funeral

Director

r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at

death with the Maryland

attending ph d for use as the funeral director, within 24 hours after death

To the Funeral Director: A

To the Hospital or Attending Physician:

Part II. Other significant conditions Above the knee of	contributing to death but not resulting in the underlying cause given in Part I. MPWTATION of Right LEG	23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ ☐ Junknow								
		24a. Was an autopsy performed? 1 ☐ Yes 232 No 1 ☐ Yes 252 No 1 ☐ Yes 252 No 2 1 ☐ Yes 252 No 2 1 ☐ Yes 252 No 2 1 ☐ Yes 252 No 2 1 ☐ Yes 252 No 2 1 ☐ Yes 252 No 2 1 ☐ Yes 252 No 2 1 ☐ Yes 252 No 2 1 ☐ Yes 252 No 2 1 ☐ Yes 252 No 2 1 ☐ Yes 252 No 2 1 ☐ Yes 252 No 2 1 ☐ Yes 2 2 1 No 2 1 ☐ Yes 2 ☐ Yes								
25. Was case referred to medical	26. Place of Death (Check only one)									
examiner? 1 ☐ Yes 🔭 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Ho									
27. Manner of Death 1		28d. Describe how injury occurred								
3 ☐ Suicide 6 ☐ Could not l 4 ☐ Homicide determined		28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										

22 South guerne Street Baltimore MD

29c. License number

P-21146

29d. Date signed (Month, Day, Year)

October 14 2007

31201

State Registrar

DHMH 17 Rev 1/2001

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Bornadette (Staton MD

MD SIATON

OCT 1 7 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Division or Vital Records, P.O. Box 68760,

22. Name and Address of Facility Cremation And Funeral Balto within 24 hours af er death.

To the Funeral Director After thi completely filled in by the funeral of Medical Certification: 🗲 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 58303 ocrosel 13 aul m 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AANON J. CHARIES TOWSON MD 4204 mo 6701 Charle ST 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 13, Kimberly 5:15 P 2007 Murray /Medical October 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Gilchrist Center for Hospice Care Towson
If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** Days Hours Months 1□ M 2 🔀 F 212-84-6944 Director 36 June 27, 1971 Maryland Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County show ns 23a or 28a-f shor must be notified at 1 ☐ Yes 2 ☑ No Director Baltimore Pikesville 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number death with 21208 U.S.A. 611 Milford Mill Road Completed by Funeral Race - American Indian, Black, White, etc. "natural", or items ? Was Decedent of Hispanic Origin? (Specify Yes or No if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or iten any Injury or other traumatic event, the Medical Examines and. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 → No Specify. 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Developing Minds Daycare 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Rita Karen Phillips Aloysius J. Murray, Jr. ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 611 Milford Mill Road Pikesville, MD R. Karen Murray-DeBus Mother 21208 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Carroll Cremation Ser. 10/17/07 Hampstead, Maryland 22. Name and Address of Facility 11824 Reisterstown Road 21. Signature of Funeral Service License 21136 ELINE FUNERAL HOME Reisterstown, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** years don concer disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Exam Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760. Physician/Medical as IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 WNo Month Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 V No this certificate 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death Check onl one Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) WISFILE 1 ☐ Yes 2 🖄 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death After 1 Certification: (Month, Day Year) Injury Natural 2 Accident 5 ☐ Pending investigation 1 □ Yes 2 □ No 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

within 24 hours after death To the Funeral Director:

in by the funeral

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 58303 derviser 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6101 N. Charles St Towson MO 21204 AMIN CHARIES wo 32 Registrar's Signature 31. Date filed (Month, Day, Year)

State Registrar

Medical

Registrar

State

31. Date filed (Month, Day, Year)

32. Registrar's Signature

LEONA MCCARTHY Baltimore, Maryland 21215-0036

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		For State Registrar		State of N	larylan	•	artment of F rtificate of	Health and N Death		giene _{Reg. No.} 2 (007	33267
Dhuniais		1. Decedent's Nam	e (First, Middle, I	Last)					2. Date of De		Year	3. Time of Death
Physicia /Medic		Leona M	ae McCa	rthy					Octobe	er 13,	2007	12:30P M
Examin	er			give street and number ntist Hosp			4b. City, Town, o	or Location of Death e			ity of Death gomery	7
Funeral		5. Social Security N		. Sex 7. A		last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	th v. Year	9. Birth	place (State or Foreign
Director		266-28-0 Usual Residence of		1 □ M 2 🛣 F	8	38 Yrs.	Months Days	Tiodis Will.	Oct 21,	1918		consin
72 hours after death with the Maryland natural", or items 23a or 28a-f show dical Examiner must be notified at	_	10a. State	10b. County			y, Town or Lo					10d. Inside City Limits 1 ☐ Yes 2 X No	
he M 28a-f otiffie	ect	MD 10e. Street and Nu	Montgon	ery	Mont	gomery	Village			10g. Citizen o	f Mhat Cour	
with tage or 3	Funeral Director	9402 Qui					10f. Zip Code 20886			USA	i wilat Cou	iuy:
ns 23 mus	era	11. Marital Status	II IIGCC	12. Was Deceden		.S. 13.		Hispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No		ace - Americ	can Indian,
after on iter			ried 2X Married	Armed Forces					Rićan, etc.)		ack, White,	etc.
ours a	d by	3 Widowed	4 Divorced	If Yes, Give Year or Dates			1 ☐ Yes 2 🗓 No	Specify:		Spec	Whi	te
72 h 72 h 'natu	Completed	(Spec	15. Decedent's cify only highest !	Education grade completed)		16a. Dece	dent's Usual Occup	pation during most of work d)	king	16b. Kind of	Business/In	dustry
filed within Hygiene. other than '	m	Elementary/Seco	ondary (0-12)	College (1-4o	5+)	Homen		(a)		Own H	ome.	
filed v Hygie ther t		17. Father's Name	(First, Middle, La	est)		nomen	llaker	18. Mother's Nam	e (First, Middle			
d be a set o ceve	To Be	William	•					Mary Nay		,		
should be and Mental in marked o	F	19a. Informant's N	ame/Relationship	(Type. Print)				and Number or Ru	ral Route Numb			
and 2 ealth a n 27 is		Charles		thy/son		reet #125	Jackso					
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.			Cremation 3	☐Removal from State	_ 4	cemetery, cre	osition (Name of matory or other pla re Cremat	ory 10/1		20c. Location - City or Town, State Beltsville, MD		
nit. P. artme artme ortant injury	4 □ Donation 5 □ Other (Specify)											
any de la constant		1/30	100 () £	#0 to	E MC			Crematio				. MD 21029
		23a. Part 1. Enter 1	the disease, or co	omplications that cause only one cause on each	ed the deat	h. Do not en	ter the mode of dyi	ng, such as cardiac	or respiratory a	rrest,	PATTIE	Approximate Interval Between
Physician	10 Y	Immediate Cause disease or condition	(Final		CARD		INFAR	CTION			- 1	Onset and Death
/Medical		resulting in death)		Due to (or a		* .		*				
Examiner	-	Sequentially list co	onditions,	b. Supr	BYE	ntricu	ILAR TA					
rited Insit	Examiner	Sequentially list co if any, leading to in cause. Enter Under Cause (Disease on that initiated event	nmediate erlying injury	0	non i							
oe exectician and surial-tra	Exa	that initiated events resulting in death)	3	Due to (or a	s a conseq	uence of):						
The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Medical	Chronic Obstructive Pulmonary Disease										
certifi nding use as	n/Me	IF FEMALE: 23b. Was deceder	nt pregnant	23c. If yes, outcom	e pf <u>pr</u> egna					23d. I	Date of deliv	ery
death	sicia	in the past 12 1 ☐ Yes 2	months?	1⊡Live birth 4⊡Pregnant 9⊡Unknown			□Ectopic pregnanc □ Other <i>(specify)</i> _	ey			Month	Day Year
ires that the designed by the a	Phys	9 Unknown		s contributing to death	but not res	ulting in the u	ındarlyina causa di	ven in Part I	23e Did	tobacco use co	antribute to t	the cause of death?
quires t	d by	. 1	bumin	_						Yes 2 No		V.
aw require s been sig 2 should b	ojete								24a. Was	an 24	b. Were auto	opsy findings available
Physician: The lav r this certificate has ral director, page 2	Completed								auto perfe 1☐ Yes	ormed? 2 X No	death? 1 ☐ Yes	ompletion of cause of 2 ☐ No
cian: ertific ector,	Be (25. Was case refe examiner?		I I a serieste			Low	26. Place of Dea	th (Check only	one)		
Physical dire	ဥ	1 Yes 2		Hospital: 1 Inpa		ER/Outpatie	11. 30 DOX		ome 5 Res			fy)
ding h.	tion:	27. Manner of Dea	5 Pending investigat	(Month, D	lay Year)	Injury	Wo	rk?]Yes 2∐No	28d. Describe	how injury occ	urrea	
Atten r deat ector: by the	ifica	2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide	6 Could no	t be 28e. Place of it	njury - At ho	ome, farm, st	reet, factory, office				mber or Run	al Route Number,
ital or irs afte rai Dir	27. Natural 5 Pending investigation 3 Suicide 4 Homicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office 28f. Location City or To									wn, State)		
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director,	Medical	29a. Certifier (Check only one)		Physician: To the best caminer: On the basis and manner:	of examina							
To th Withir To th COMP	Me	29b. Signature and	title of certifier	***			29c. Licen			29d. Date sig		
4		7	Tell	AZ			1 120	0571	(Oct. 13	3,200	27
20		30. Name and add	Mizus	no of mpleted cause of	death (Iten	n 23a) (Type,	St. #S	0571 500 KEI	Isine	on M	1 20	0895
Sta	- 1	31. Date filed (Mor		32. Regis	trar's Signa	ature	les .	110				
Registr	ai	00	T1720	UI		1						

ion of Vital Records, P.O. Box 68760,

To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dir

Medical (Check only and manner stated. 29b 29c. License number 29d. Date signed (Month, Day, Year) signature and October 15, 2007 D32610 ne and ad less of person who completed cause of death (Item 23a) (Type, Print) /J. McNamara, M.D., 10215 Fernwood Road, Bethesda, Maryland 20817 Thomas 31. Date filed (Month, Day, Year) State OCT 1 7 2007 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Chung Ja	ı Kim	Mitchell
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		- For State	,		Certifica	ate of	Death			R	eg. No	707	3320
Physicia Vedical Examin	ın/	1. Decedent's Name (First, Middle Chu		Kim M	iitche					Date of Dea Month October 1	Day Year 1, 2007	2	ime of Death
		4a. Facility Name (if not institution 10415 Montross Aven	_	umber)		41	b. City, Town, o Bethesda	or Location o	of Death		4c. County of Montgome		
Funeral		5. Social Security Number	6. Sex	7. Age (In	yrs. last birt	hday)	If Under 1 Ye					Foreign	
Director	L	578-60-9956	1 M 2 X F	80		Yrs.	Wortus	lys Hours	IVIIII.	July	15, 1927	Country	Korea
any	ŀ	Usual Residence of Decedent 10a. State 10b. County		10c.	. City, Town	or Location	on	-				100	I. Inside City Limits
	٦	Maryland Mon	tgomery		Ве	ethes	da					1	Yes 2 X No
th the Maryland 23a or 28a-f sho notified at once.	Director	10e. Street and Number			_		10f. Zip Code				l0g. Citizen of Wha	-	1
th the 23a or notifie	Ö	10415 Montro		ecedent Ever		12 14/00	Decedent of H	20814	nin? / Sner	rify Ves or N	United		S Indian, Black,
eath wi	Funeral	11. Marital Status 1 Never Married 2 M	larried Armed F				es, specify Cub				White,		maan, bloom
after de al", or	by Fu		vorced If Yes, Give Ye	ear			Yes 2 X				Specify:		
hours 'natur	ed	15. Decedent's Education (Spe		ade complete (1-4 or 5+)	ed) 16a.		's Usual Occup est of working li				16b. Kind of Busi	ness/Indus	stry
36 hin 72 than tedical	Completed	Elementary/Secondary (0-12)	5-		Н	omema	aker				Own Ho	me	
5-0036 iled within 7 Hygiene. I other than		17. Father's Name (First, Middle	, Last)					18.Mother	's Name (I	First, Middle,	Maiden Surname)		
2121 ould be fil Mental I marked ic event,	Be	Unknown 19a. Informant's Name/Relations	shin (Tyne Print)		10	h Mailing	Address (Str	eet and Nur		Soon I	Park mber, City or Town,	. State, Zir	Code)
MD 2 d 2 shou ith and N a 27 is n	٩	Allen O. Mitch			13	3400 M	ill Swa	amp Ro			ield, Vii		
re, re, rand rand return		20a. Method of Disposition 1 Burial 2 X Crematio	n 3 Removal	from State	20b. Place	of Disposi tory or oth	tion (Name of o	cemetery,	Octo	Date ber	20c. Location - 0	City or Tow	vn, State
Baltimore, permit. Pages I ar Department of Hee Important: If ite		4 Donation 5 Other S	pecify:	II OIII OLLIO	Crema	toriu	ım, Inc			2007	Bethesd	a, Ma	ryland
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once		21. Signature of Funeral Service (My Lette Car)	Licensee	мС	1305	22. N Rob	ame and Addre	ess of Facilit imphrey	Funer	cal Home	/Bethesda-	Chevy	Chase, Inc. -3501
Physician	┪	23a. Fart I. Enter the disease, o				ot enter th	e mode of dyir	ig, such as o	ardiac or i	respiratory a	rest, shock, or hear	rt A	pproximate Interval Between Onset and
/Medical xaminer		Immediate Cause (Final disease a, Asphyxia											
,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		or condition resulting in death)	Due to (or as	a conseque	ence of):								
	힐	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	Due to (or as	a conseque	ence of):								
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760, reate be executed physician and the burial - transit			d									-+	
760, Treate be executed a physician and the burial - transi	Medical	UNPENDED IF FEMALE:	AMENDED		of pregnancy	,					23d. Date of o	delivery	
6876 ertificat fing phy		23b. Was decedent pregnant in t past 12 months?	the 1 Live	birth			tal death	3 Ectop	ic pregnan	су	Month	Day	Year
Box 687 ne death certific the attending	ysician	1 Yes 2 No 9 Ur	diameter	gnant at time nown	e or death	5 Otl	ner (Specify)				U.		
O. Enat the of the etached	y Phy	Part II. Other significant condi	itions contributing	to death bu	t not resultir	ng in the u	inderlying caus	e given in P	art I.		tobacco use contrib		
S, P uires th n signe Id be d	ed by	Breast carcinoma					<u> </u>			1 Y	es 2 V No 3		sy findings available
cord aw req has bee 2 shou	ompleted		······································							auto per	opsy proformed? de		pletion of cause of
Rec: The liftcate	O	25. Was case referred to medic					26 PI	ace of Death	(Check o		2 V No 1	Yes	2 No
Vital ysician his cert directo	o Be	examiner?	Hospital: 1	Inpatient	2 ER/0	Outpatient		Other ₄		Home 5	Residence 6	Other: So	cene
on of Anding Ph. th.	\vdash 1	27. Manner of Death	28a. Da Oct 10	te of Injury hth Day Year)), 2007		Time of I 00 hrs	′′ _	njury at Wor Yes 2 ∨	_ 9		e how injury occurre it plastic bags (ad
Division of Vital Records, P.O. Istal or Attending Physician: The law requires that the rs after death. "In Director: After this certificate has been signed by the funeral director, page 2 should be detach	ertification:	3 Suicide 6 Cou	ald not be	ace of Injury		farm, stree	et, factory, offic	e building, 6		or Town,			Route Number, City
Division of Vital Records, P.O. Box 68' To the Hospital or Attending Physician: The law requires that the death certiff within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	edical Ce	29a. Certifier (Check only one) 2 Medical Ex	Physician: To the basi	est of my kn	owledge, de	eath occur	red at the time	, date and p	lace, and o	due to the ca	use(s) and manner	as stated.	
To To Com	Med	29b. Signature and title of certif	and manner	stated.			29c. Lice	ense numbe	r		29d. Date signe	ed (Month,	, Day, Year)
		Caliele	1	A			0.0	C.M.E.			October 12	, 2007	
30		30. Name and address of perso					n Street, B	altimore	MD 212	201			
	tate	Zabiullah Ali, M.D. 31. Date filed (Month, Day, Year	Assistant Med	Registrar's					1012 612		-051		
Regis		OCT 1 7	0007	due	Di.	Goes					DCME		
DHMH 17 Rev 1/2	001		•		0	ŔIGINA	L						

		State Registrar				Ce	rtificate of	Death			g. No. 20	07	3327
Physicia /Medica	n	1. Decedent's Nam	e (First, Middle, Phi		Clean					Date of Death Month ctober	_) 0 7	3. Time of Death 2:30 P
Examine	_			give street and number)			4b. City, Town, o		Death		4c. County	of Death	
			n Hospi				Bethe		Ura la	D 1 - 1 D 1	Mont		
uneral irector		5. Social Security Number 480-40-8228 G. Sex 1 ★ M 2 □ F 69 Yn Usual Residence of Decedent					Months Days		Min.	Date of Birth (Month, Day, vember]		9. Birthp Cour Iowa	
show d at		10a. State	10b. County			Town or Lo	ocation	-				1	10d. Inside City Limit
28a-f notifie	2	Maryland 10e. Street and Nu		mery	Pot	omac	10f. Zip Code			10	g. Citizen of V	Vhat Cou	
3a or		8320 Ra	ymond La	ane			2	0854			United	Stat	tes
xan	by Fur	11. Marital Status	ried 2 X Marrie	12. Was Decedent Armed Forces?		0-	Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 No	lispanic Origin an, Mexican, F Specify:	? (Specify Puerto Rica	Yes or No- an, etc.)	Blac	e - Americk, White,	
Jical E	eted	(Spec	15. Decedent's	Education grade completed)		16a. Dece	dent's Usual Occup kind of work done DO NOT use retired	ation during most of	f working		6b. Kind of Bu Jnited		
than the Me	Completed	Elementary/Seco	ondary (0-12)	College (1-4or 5	5+)		DO NOT use retired ic Health						th Servic
other ent, th	Be Co	17. Father's Name	(First, Middle, L			I GDI.	ic nearen			rst, Middle, M	laiden Surnam	ne)	
rked c	To B	Vincent	McClean	n				Lori	raine	Barne	tt		
is ma auma		19a. Informant's N	ame/Relationshi	o (Type. Print)		19b. Maili	ng Address (Street	and Number o	or Rural R	oute Number,	City or Town,	State, Zip	Code)
m 27 her tr		Sally E.		n / Wife	Tool Di		Raymond :	Lane, I					
int: If Itel				B □Removal from State	cei	metery, cre	osition (Name of matory or other place eart Ceme		ctobe 8. 20	r l	oc. Location -	•	
Importa any inju		21. Signature of Fu	uneral Service Li		M01305	_ RC	2. Name and Addre	ss of Facility	uneral	. Home/R	ockville	, Inc	20850-2805
edical		resulting in death)		Due to (or as	a conseque	ence of\:							
burial-transit	al Examiner	Sequentially list or if any, leading to ir cause. Enter Under Cause (Classas or that initiated event resulting in death)	s injury	b. Due to (or as	a conseque	ence of):							
P_k		that initiated events	t pregnant ? months?	c	a conseque a conseque pf pregnan 2 □ Fetal o	ence of): ence of): ency death 3[⊒Ectopic pregnanc □ Other (specify) _	у				te of deliv	ery Day Year
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ral Director: After this certificate has been signed by the attending physician and lled in by the funeral director, page 2 should be detached for use as the burial-transit	To Be Completed by Physician/Medical	IF FEMALE: 23b. Was deceder in the past 12 1	int pregnant months? No ifficant condition ancer, in pathy rred to medical No th 5 Pending investiga 6 Could no determin	Due to (or as d. 23c. If yes, outcome 1 Live birth 4 Pregnant a 9 Unknown as contributing to death by Peutropenia. Hospital: 1 Ninpation (Month, Dailed ed 28e. Place of injuilding, et between 1 b	a conseque a conseque a conseque properties a conseque properties a conseque a cons	ence of): ence of): ence of): ency death 3 [ath 5 [ting in the u pmbocy ER/Outpatie 28b. Time c Injury ne, farm, st	other (specify) underlying cause giver topenia nt 3 DOA Other of 28c. Inju Wo M 1 reet, factory, office th occurred at the tinvestigation, in my 29c. Licens	26. Place of her: 4 Nursiny at k? Yes 2 No me, date and popinion, death see number	28d 28f. place, and occurred	1 ☐ Ye 24a. Was ar autops; perform 1☐ Yes 2 theck only one 5 ☐ Reside Describe ho Location (Str. City or Town due to the cat the time, dat	acco use cont s 2 2 No 24b. yed? No nce 6 Oth w injury occur weet and Numb state and place, od. Date signe	ribute to to the state of the s	bably 4 Unknow Day Year the cause of death? bably 4 Unknow Day findings availate Day No State Number, Stated. To the cause(s)
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			1 - State of M Registrar	aryland /	Depa / Cer	irtment of H <i>tificate of L</i>	ealth and N D <i>eath</i>		giene Reg. No.		33271
SQ.	Dharisi		Decedent's Name (First, Middle, Last)					2. Date of Dea			3. Time of Death
	Physici /Medio			ALAT	7			October		2007	3:40 pm
	Examin	er	4a. Facility Name (If not institution, give street and number)	JI.			Location of Death			County of Death	
	Funeral		803 N. Marlyn Avenue 5. Social Security Number 6. Sex 7. A	ge (In yrs. last	birthday)	Essex If Under 1 Year	If Under 24 Hrs.	8. Date of Birtl	h	Baltimor 9. Birtho	ace (State or Foreign
В	Director		218–38–1466 ^{1□ M} 💯 F	65	Yrs.	Months Days	Hours Min.	(Month, Day 5/19/1	y, Year) 942	Coun	rland
	and w		Usual Residence of Decedent 10a. State 10b. County	10c. City, To	own or Lor	cation					0d. Inside City Limits
	Maryla f sho	or	Maryland Baltimore	_						,	1 ☐ Yes 2 🛣 No
	r 28a-	Director	10e. Street and Number	Esse:	Λ	10f. Zip Code			10g. Citiz	en of What Coun	try?
	th with 23a o		803 N. Marlyn Avenue			21221			U.S	. A.	
	er dea items	Funeral	11. Marital Status 12. Was Decedent Armed Forces'	?	13. V	Vas Decedent of His Yes, specify Cuba	spanic Origin? (Sp n, Mexican, Puerto			4. Race - America Black, White, e	
36	72 hours after death with the Maryland 'natural', or items 23a or 23a-f show 'Geal Examiner must be notified at	by F	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates:	No	1	□Yes 2XNo	Specify:			Specify:	+-
21215-0036	72 hou natura Ical E	ted	15. Decedent's Education (Specify only highest grade completed)	10	6a. Deced	ent's Usual Occupa	ution	ina II	16b. Kin	Whi nd of Business/Ind	
21	ithin 7	Completed	Elementary/Secondary (0-12) College (1-4or	5+)		kind of work done d OO NOT use retired,	uning most of work)	arig			
	filed w Hygie ther ti		11 17. Father's Name (<i>First, Middle, Last</i>)		Seam	<u>stress</u>	18. Mother's Nam	e (First Middle		thing	
lan	id be ental ked o	To Be	William Stull				Alma	Earlev		ourname)	
Maryland	shou and M s mar	-	19a. Informant's Name/Relationship (Type. Print)	1	9b. Mailin	g Address (Street a				Town, State, Zip	Code)
Σ,	is 1 and 2 of Health a item 27 Is other trai		Donna Kaye Gain (Daughter)			33rd Stre				and 2123	
altimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State	0.000	e of Dispos etery, cren	sition (Name of natory or other place	a) 1	Date /17		cation - City or To	
Ħ	artmer artmer ortant Injury		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee	Holly		1 Mem. Ga Name and Addres		ן 'לֹי	Midd:	le River	, Maryland
Ba	Depar Impor any Ir		Michael P Julla So		Br	uzdzinski 07 old E	Funeral	Home P	A	, Maryla	nd 21221
			23a. Part1. Enter the disease, or complications that cause shock, or heart failure. List only one cause on each I	d the death. D	Do not ente	er the mode of dying	g, such as cardiac	or respiratory ar	rest,	ratyra	Approximate Interval Between
1	Physician	80 17	Immediate Cause (Final disease or condition	STATIC	1	REAST (1/	Onset and Death
	/Medical Examiner		resulting in death) Due to (or as	a consequent	ce of):	14					T
		er	Sequentially list conditions, b. Dann to (or see	e consequenc	no of):						
y	cuted nd ransit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as								
90,	be execian a	I Ex	Due to (or as	a consequenc	ce of):				-		
68760,	icate be executed physician and s the burial-transit	edical	d								1.0001
×o	w requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	n/Me	IF FEMALE: 23c. If yes, outcome						23	3d. Date of delive	гу
P.O. Box	e death	Physician/M	in the past 12 months? 1 Yes No 9 Unknown			Ectopic pregnancy Other (specify)				Month	Day Year
<u>Р</u>	d by the		9 ☐ Unknown 9☐ Unknown Part II. Other significant conditions contributing to death t	out not resulting	a in the un	darlying egues givo	o in Port I	220 Did to	hanna ua	o contribute to th	e cause of death?
Division or Vital Records,	uires t signe Id be c	d by	Tak in Strict Significant Conditions Continuously to Gealing	at not resulting	g iii tile uii	denying cause give	ii iii i aiti.	1 □ Y			ably 4 Unknown
COL	s beer shou	Completed						24a. Was a	an l	24b. Were autor	psy findings available
Be	The lav	шо						autop			pletion of cause of
/ita	ding Physician: The h. After this certificate he funeral director, page	Be C	25. Was case referred to medical examiner?				26. Place of Deat				
or.	Physic this c	은	1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpati 27. Manner of Death 28a. Date of Inju		Outpatient b. Time of		4 ☐ Nursing Ho	ome Resid		Other (Specify)
ou	th. : After	tion	1 → Natural 5 → Pending (Month, Date 2 → Accident investigation	y Year)	Injury	28c. Injury Work M 1 ☐ Y	es 2 □ No	zou. Describe ri	ow injury	occurred	
N N	Attence or death	Certification:	3 Suicide 6 Could not be 28e. Place of in	jury - At home, tc. (Specify)	, farm, stre	et, factory, office		28f. Location (S City or Tow	treet and	Number or Rural	Route Number,
ō	ital or rrs afte ral Di										
	To the Hospital or Attending Physician: The law requires that the death certif within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Medical	29a. Certifier (Check only one) Certifying Physician: To the best 2 Medical Examiner: On the basis of and manner st	of examination	dge, death and/or inv	occurred at the tim estigation, in my op	e, date and place, pinion, death occur	and due to the or red at the time, or	ause(s) a date and p	and manner as sta place, and due to	ated. the cause(s)
	To the within To the comple	Me	29b. Signature and title of certifier			29c. License				signed (Month, L	*
			hardend fine be	1		233	551	C	3ct.	15, 20	007
	0		30. Name and address of person who completed cause of c			Print)	55) "4, BAI	/,		7 122	7
	Sta	to.	31. Date filed (Month, Day, Year) 32. Registr	rar's Signature	pro A	10 1771	Y, 00	TIME	e.	ules !	
	Registr		OCT 1 7 2007 July	9,	600	Walt of					

Division or Vital Records, P.O. Box 68760,

Funeral Dietely filled in within 24

> State Registrar

29a. Certifier (Check only one)

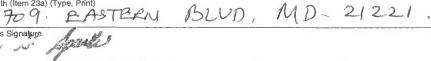
29b. Signature and little of certifier

WASERM 32 Registrar's Signature 31. Date filed (Month, Day, Year) 2007

M-D

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.



12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year) 10-16-2-007

			1 - State Registrar	State of Marylan	d / Department of H Certificate of L		ntal Hygien	.001	33273
П	Physici	an	1. Decedent's Name (First, Middle, Last,	Di-tro		2	Date of Death Month	ay Year	3. Time of Death
	/Medic Examin	al	4a. Fecility Name (If not institution, give	street and number) 210	Fair Manding Colony or	Location of Death	10 0	c. County of Deat	th
	Exami	lei	Fairland Nu	rsince Reha	- 10	ersprind		mont	gomery
	Funeral Director		7 75 FO 6001	7. Age (In yrs.	Ast birthday) If Under 1 Year Months Days	If Under 24 Hrs. 8 Hours Min.	Date of Birth (Month, Day, Year 01-30 -1	9. Birt	puntry) unk
	yland iow		Usual Residence of Decedent 10a. State 10b. County	10c. Cit	y, Town or Location				10d. Inside City Limits
	e Man	ctor	MD Montgon	ery Z	sethes da	mD 2	-08/4		1 ☐ Yes 2Ã ☐ No
	with th	Funeral Director	10e. Street and Number	7-11/0 C+ H	10f. Zip Code	0.116	10g. C	itizen of What Co	ountry?
	death ms 23	neral	11. Marital Status Un KNOWN	12. Was Decedent Ever in U	Sunk 13. Was Decedent of Hi	ispanic Origin? (Specif	y Yes or No-	USA 14. Race - Ame	
900	72 hours after death with the Maryland natural', or Items 23a or 28a-1 show deat Exarterer ment be notified at	þ	1 Never Married 2 Married 3 Widowed 4 Divorced	1 Yes 2 No If Yes, Give Year or Dates:	If Yes, specify Cuba	n, Mexican, Puerto Ric	an, etc.)	Specify: B	iack
21215-0036	within ene. than "	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12) unk un	e completed) College (1-4or 5+)	16a. Decedent's Usual Occup: (Give kind of work done of life. DO NOT use retired	turing most of working	unk 16b. F	Kind of Business/	/Industry un
Maryland 2	be filed Ital Hyg od othe event,	To Be C	17. Father's Name (First, Middle, Last)		unk	18. Mother's Name (F	First, Middle, Maide	n Sumame)	unk
lary	and and sum	-	19a. Informant's Name/Relationship (Ty	рө, Print)	19b. Mailing Address (Street a	and Number or Rural R	oute Number, City	or Town, State, 2	Zip Code)
	s 1 and 2 of Health item 27 other tra		Fairland Nursing &		2101 Fairland		-		
Baltimore,	Pages nent of ant: if it		20a. Method of Disposition 1 □ Burial 2 □ Cramation 3 □ 4 □ Donation 5 ☑ Other (Specify)	in state	Mace of Disposition (Name of emetery, crematory or other plac		20c. t	_ocation - City or	Town, State
Ball	permit. Pag Department Important: any injury o		21. Sign turn of Funeral Service Licens Ronal & S.	1100	Baltimore,	omy Board 6 MD 21201		ltimore	Street
			23a. Part Enter the disease, or compleshock or heart failure. List only or	cations that caused the death ne cause on each line.	h. Do not enter the mode of dying	g, such as cardiac or re	espiratory arrest,	-	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Osuse (Final disease or condition resulting in death)	Due to (or as a consequence	Cory Fai	luge,	Prosta	tie	
	Examiner		Sandania in the sandania in th	CAOcinan	CHF	- H-	FW.		
	sit ad	Iner	if any, leading to immediate cause. Enter Underlying	Due to (or as a consequent	uence of):				
	icate be executed physician and the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence)					
38760	ysiciar e buria	dical	L,	d					
-		a)	IF FEMALE:		3000				
.O. Box	he death certific the attending p	Physiclan/Mo	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome of pregna 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of di 9 □ Unknown	I death 3 Ectopic pregnancy]	23d. Date of deli Month	livery Day Year
ls, P.	law requires that the de as been signed by the 2 should be detached	by Ph	Part II. Other significant conditions cor	ntributing to death but not resi	ulting in the underlying cause give	en in Part I.	23e. Did tobacco	use contribute to	the cause of death?
ords	w require: been sig should b						1 ☐ Yes 2	2□No 3□Pr	robabły 4 Unknown
Record	The ate has page	Completed					24a. Was an autopsy performed?	prior to death?	utopsy findings available completion of cause of
Vital	Phyalcian: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?	lospital:	Othe	26. Place of Death (C			
of		.: To	1 Yes 2 No	1 ☐ Inpatient 2 ☐ 28a. Date of Injury (Month, Day Year)	ER/Outpatient 3 DOA Othe	Nursing Home	5 Residence I. Describe how inju		city)
ion	Attanding Phy ir death. ector: After thi by the funeral o	atlor	t Natural 5 ☐ Pending ☐ Accident investigation	(Month, Day Year)	Injury Work	k? Yes 2 □ No			
Division	i Çir	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At he building, etc. (Specify	ome, farm, street, factory, office	28f	Location (Street a City or Town, Stat	nd Number or Ru e)	ıral Route Number,
	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	edical (29a. Certifier (Check only one) Certifying Physical Medicel Exemination	sicien: To the best of my kno ner: On the basis of examina and manner stated.	wledge, death occurred at the tim tion and/or investigation, in my op	ne, date and place, and pinion, death occurred	I due to the cause(s at the time, date an	s) and manner as id place, and due	stated. to the cause(s)
1	Withir Comp	M	29b. Signature and title of certifier		29c. License	number	29d. Da	ate signed (Mont)	h, Day, Year)
			30. Name and address of person who co	empleted cause of death (Item	1 23a) (Type, Print)	1075/1	9	1 > 1	
	Sta	to	Mehmoda 31. Date filed (Month, Day, Year)	Nosem	mi Fair	land	Nurs	ingd P	ehab.
	Registr		OCT 1 7 200	37 Begistrar's Signa	& sparter				

State of Maryland / Department of Health and Mental Hygienes 33274 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Year 041PM Saverio MUSTO 2007 O Cipler /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Howard County General Hospital Columbia Howard 6. Sex 1 M 2 □ F If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year Birthplace (State or Foreign Country) **Funeral** Months Days Hours 288-30-7640 76 Yrs. Director New York OCT 11, 1930 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f ehow the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Anne Arundel **Odenton** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or 2637 Midway Branch Drive, Apt. 102 21113 USA 12. Was Decedent Ever in U.S. Armed Forces? or Itame 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status hours after 1 XYes 2 No If Yes, Give Year or Dates 1948—1972 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: 2 id 2 should be filed within 72 hours the and Mental Hygiene. 27 fe marked other than "natural; traumatic event, the Medical Ext 3 X Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) U.S. Army Soldier 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Musto Giuseppe Filumina 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If Item 27 te m eny injury or other traum once. John N. Strange, friend P.O. Box 2289 Annapolis, MD 21404-2289 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Baltimore, MD 4 □ Donation 5 □ Other (Specify) Metro Crematory, Inc. 10/09/07 21. Signature of Funeral Service Licensee George MacNabb 22. Name and Address of Facility Cremation Society of MD, Inc. E. Mar Hoff 299 Frederick Road Baltimore, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last sclevolce (tendrovancular De Bern use as the burial-transit Box 68760. physicien Physician/Medical d ettending 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy signed by the ette Month Day Year 4□Pregnant at time of death 5 Other (specify) Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 Yes 2 No 3 Probably 4 Unknown been si Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an s certificete has t lirector, page 2 s autopsy performed' 1☐ Yes 2 of Vital Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 100 2 ER/Outpatient 3 DOA 1 Tes 1 Inpatient this To the Funeral Director: After th completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? Certification: Division or Attending 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide efter To the Hospital o within 24 hours eff To the Funeral Di 1/2 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D30641 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RIVER NECK ROAD SEPAMURE Sabapalli 201-109 15906 31. Date filed (Month, 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 7:00AM /Medical 4a. Facility Name (If not institution, give street and number) City, Town, or Location of Death 4c. County of Death Examiner Isto sal timore 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1**∑**M 2□F Months Hours Min Director 212-66-2304 50 8/10/1957 Conn Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Examiner must be notified at Director XX es 2 No Wicomico Md. Salisbury 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 'natural", or items 23a 1013 Adams Avenue 21804 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Never Married 2X Married 1 XYes 2 ☐ If Yes, Give Year or Dates: 2 No 1 ☐ Yes 2 X No Specify ٥ Specify: 3 Widowed 4 Divorced Black Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Supervisor **84** Lumber Company 7 Is marked other traumatic event, the 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) h and Mental h Be William Nunn Sarah Douling 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If Item 27 Is any injury or other tra once. Yashira Nunn Daughter 806 Lynnhaven DRive,Pocomoke City,Md.21851 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ➡Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Macedonia Mem. Pk. 10/20/2007 Westover, Md. 21. Signature of Funeral Service Licens ^{22 Name and Address of Facility} Bennie Smith Funeral Home 917 W.Isabella St.,Salisbury,Md. 400875 ollige 23a. Part1. Enter the disease, or complication shock, or heart failure. List only one can that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, se on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a conse un nce of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner burial-tran Due to (or as a consequence of) Physician/Medical the attending ph for use as the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a detached f 9☐Unknown 9 ☐ Unknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 ☐ NO 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 24a. Was an certificate has autopsy performe

Physician /Medical Examiner

filed within 72 hours after death with the Maryland

1 and 2 should be Health and Mental

Maryland 21215-0036

Baltimore,

page 2 s funeral director,

Physician: The law requires that the death certificate be executed

this

After t

death.

24 hours after death e Funeral Director:

within 24

filled in by

completely

Medical

Hospital or Attending

Division or Vital Records, P.O. Box 68760

Completed by 25. Was case referred to medical examiner?

1 ☐ Yes 2 ☐ No

5 Pending

6 Could not determine

investigation

27. Manner of Death

1 Natural

2 Accident

3 ☐ Suicide

4 ☐ Homicide

Be Certification: To

2 ZHV0

24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No

4					26.	Place of Dea	eath Check onl one	
Н	ospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient	3 🗆 [DOA	Other: 4	4 Nursing H	Home 5 ☐ Residence 6 ☐ Other (Specify)	
	28a. Date of Injury (Month, Day Year)	28b. Time of Injury		28c.	Injury at Work?		28d. Describe how injury occurred	
on			M		1 ☐ Yes	2 □ No		
be d	28e. Place of injury - At h building, etc. (Special	ome, farm, stree	t, facto	ory, of	fice		28f. Location (Street and Number or Rural Route Number City or Town, State)	∍ <i>r</i> ,

29a. Certifier (Check only one)	1 Certifying Physi 2 Medical Examin	clan: To the best of my ler: On the basis of exam	knowledge, death occ nination and/or investig	urred at the time, date and place, and due to the pation, in my opinion, death occurred at the time	ne cause(s) and manner as stated. i.e., date and place, and due to the cause(s)
		and manner stated.			
29b. Signature an	d title of certifier	1/1//		29c. License number	29d. Date signed (Month, Dav. Year)

30. Name and address of person who completed of death (Item 23a) (Type, Print)

32. Registrar's Signature

State Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2007

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Total Private Name (First, Micde, Last) State St	020	ours after de ral', or items Exerière	þ	V If Van Chia	If Yes, specify Cub		ecify Yes or No- Rican, etc.)	Black,	White, etc.			
Total Private Name (First, Micde, Last) State St	2-0	72 hc	ied	15. Decedent's Education (Specify only highest grade completed)	16a. Decedent's Usual Occup	ation	ina	6b. Kind of Busin	ness/Industry			
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Physician Medical Examiner Part Control		nt.		23a. Part Enter the disease, or complications that caused the death					Approximate			
Due to (or as a consequence of): Due to (or as a consequence of):		Physician	ì	Shock, of fleat failure. List only one cause of each line.					Onset and Death			
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29a. Certifier (Check only one) 29a. Certifier (Check only one) 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ARW J. CHANGS WD 6701 N. Change) 29a. Certifier (Check only one) 29a. Certifier (Check only one) 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0170Ben 12 2007	=	iclan certif recto		examiner?	Oth							
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29a. Certifier (Check only one) 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 12 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AANON J CHANGS MO 6701 N Change ST TOWSON MO 21204	DIVIS	* # = c	ertifica	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At hor			28f. Location (Stre City or Town,	et and Number o State)	or Rural Route Number,			
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30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ARON J. CHARLES MO 6701 N. Charles ST TOWSON M.D. 21204 State 31. Date filed (Month, Day, Year) 32 Registrar's Signature		->=0		> Wharias		58303	3	TORES	12 2007			
State 31. Date filed (Month, Day, Year) 32 Registrar's Signature	7	15		30. Name and address of person who completed cause of death (Item AAA)) CHAP CR W C-70	23a) (Type, Print)	77721.30)	NMO	21204	4			
		Sta	e.	31. Date filed (Month, Day, Year) 3 Registrar's Signati	ure	,0.00						

State of Maryland / Department of Health and Mental Hygiene 007 1- State Registrar Amend Item 26 per verb., g872 10/17/207 hbeath 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** 2007 October 4, 10:13 PM M James Patrick O'Donovan /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Baltimore 1930 Merritt Blvd 8. Date of Birth (Month, Day, Year) Mar 19, 1920 If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country)
 Maryland 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1⊠M 2□F Months 87 Director 219-12-5597 Usual Residence of Decedent death with the Maryland 10c City Town or Location 10d. Inside City Limits 10a. State 10b County rthen "naturel", or Iteme 23a or 28e-f ehow tre Medical Examinar must be notified at 11 Yes 2 □ No Director Baltimore MD 10g, Citizen of What Country? 10f. Zip Code 10e. Street and Number 21205 IISA 5071 Orville Avenue Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 23 Yes 2 □ No If Yes, Give Year or Dates: 137-45 within 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White þ 3 XWidowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) e filed within Il Hygiene. other than Elementary/Secondary (0-12) automotive mechanic 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Heelth and Mental Hy important: if Item 27 is marked oth any injury or other traumatic event 90cg. 17. Father's Name (First, Middle, Last) 86 Cathleen C. O'Donovan Andrew Fry 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Bonnie Powell/step daughter in law 439 Polar Lane Annapolis, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 X Donation 5 Q Other (Specify) Nrect r 21. Signature of Funeral Single Licensee Round of S. Wade, 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street more Baltimore, MD 21201 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) CORONARY YEARS **Physician** ARTERY DISCASE /Medical Due to (or as a consequence of): ASCVD Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed Due to (or as a consequence of): ed by the ettending physicien detached for use as the buria Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Year Month Day 4□Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No o 9 Unknown 9 I Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed Records. 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No been s 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an NIDDN has 1 Yes 2 No 1 ☐ Yes 2 ☐ No certificate of Vital director. 25. Was case referred to medical examiner? 8 26. Place of Death Check only one Friend's Other: 4 Nursing Home 5 Nother (Specify) Residence Hospital: 1 Yes 2 No ٩ 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death

1 Natural
2 Accident 28c. Injury at Work? 28d. Describe how injury occurred funeral 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: After Division or Attending 5 Pending investigation after death. 1 ☐ Yes 2 ☐ No completely filled in by the 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, lactory, office building, etc. (Specify) 4 T Homicide within 24 hours a Hospitel 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D 28987 who completed cause of death (Item 23a) (Type, Print) RAVOU BLUD 5601 32. Registrar's Signature 31. Date filed (Month, Day, Year) State goods? Registrar 2007

State of Maryland / Department of Health and Mental Hygien 1 - For Stata Ragistrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Month **Physician** 10 14 2007 6:52p. Dorothy Osborne /Medical 4c. County of Deeth 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Future Care Nursing Home If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 10 17 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Months Min. Hours 1 ☐ M 2 🕱 F Director 72 34 NC 214-56-9007 Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28e-f show : if Item 27 is marked other then "neturel", or Items 23e or 28e-1 sho or other treumetic event, It a Macilcal Examinar must be notified at Baltimore 1 TWes 2 □ No NA MD Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21217 U.S.A. 2722 Parkwood Ave Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Importent: If Item 27 is marked other then "neturel; or Iten eny injury or other freumetic event, the Maulical Exemples. Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Black Specify: þ 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Home Care Nurse Private Homes 12th grade na 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Alean Blande Davis John Henry Phillips Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3026 Wayne Ave, Baltimore, Md 21207 Calvin L. Osborne Sr.-Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Memorial Park 10/20/07 Randallstown, King 21. Signature of Funeral Service Licensee Narch F/H West 4300 Wabash Ave, Baltimore, Md 21215 23a. Pant Enter the disease, or complications that baused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a Meta Static Non-Small (arcinoma Lyng Due to (or as a consequence of): Approximate Interval Between Onset and Death Pnysician /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, any, leading to infine dide cause. Enter Underlying Cause (Disease or injury that initiated events) lead Due to for as a nonsequence off Examiner requires that the death certificate be executed the attending physician and hed for use as the burial-transit resulting in death) Last Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 1 Live birth 2 ☐ Fetal dea 4 Pregnant at time of death 2 Fetal death in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 5 Other (specify) detached 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ page 2 should be 1 ☐ Yes 2 ☐ No 3 Probably 4 Monknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed 200 certificate 1 ☐ Yes 1 Yes 2/2 No To the Hospitel or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Jursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA Certification; To this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manne of Death 28b. Time of Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funerel Director: A investigation 2 Accident 6 Could not be determined 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by 4 - Homicide l 🗲 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 00057465 pameMD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ruisterstonn 21136. 25 Main St., Suite 200 N. 5 Kajapakse MD 31. Date filed (Month, 32. Registrar's Signature Year) State 2007 Registrar

State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Day October 13, 2007 0116 hrs Medical Examiner Joseph Paparo John 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Cecil Perrvville 310 Mansion Drive Apt 11 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year If Under 24Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Foreign Pennsylvania Country) Months Days Hours Director 17,1964 174-60-2328 1 × M 2 F Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. Count 1 X Yes 2 No Maryland Perryville 28a-f show Cecil notified at once, Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 310 Mansion Drive Apt 11 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, Funeral 11 Marital Status 12. Was Decedent Ever in U.S must be White, etc. Never Married 2 Married Yes Specify: White Yes 2 X No specify: If Yes, Give Year after Widowed 4 X Divorced permit. Pages I and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", injury or other traumatic event, the Medical Examiner. <u>\$</u> 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed College (1-4 or 5+) Elementary/Secondary (0-12) Healthcare MD 21215-0036 Sales 2 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Marilyn Craiq Be Nicholas Paparo Joseph 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Hunt Drive Laurie S. Doran / Coatesville, PA 19320 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition Baltimore, crematory or other place) Burial 2 X Cremation 3 Removal from State Hanover, MD October 16,200 Ardent Cremations 4 Donation 5 Other Specify: 22. Name and Address of Facility Ardent Cremations 21. Signature of Funeral Service Licensee Hanover, MD 21076 7522 Connelley Drive Suite N. Laura C. Hardesty 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and failure. List only one cause on each line Medical Death Ethylene glycol intoxication Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions Due to (or as a consequence of): if any, leading to immediate Examiner enune. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last requires that the death certificate be executed Physician/Medical X UNPENDED #23a.27 ending physician use as the burial perME.g874. 12/13/07 TT 28a-f. Box 68760, 23d. Date of delivery IF FEMALE: Year 23b. Was decedent pregnant in the Day 3 Ectopic pregnancy Month Live birth Fetal death past 12 months? Pregnant at time of death Other (Specify) 5 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Yes 2 ✔ No 3 Probably 4 Unknown Completed Records, 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy performed? 1 ✓ Yes 2 death? certificate has 1 🗸 Yes the Hospital or Attending Physician: Ti in 24 hours after death. the Funeral Director: After this certifica inpletely filled in by the funeral director, pr 26.Place of Death (Check only one) 25. Was case referred to medical Division of Vital Be Other₄ Hospital: examiner? Residence 6 Other: Scene Nursing Home 5 Inpatient 2 ER/Outpatient 3 DOA 1 🗸 Yes No 28d. Describe how injury occurred 28c. Injury at Work? 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury Manner of Death Certification: subject ingested ethylene glycol Natural Yes 2 XNo Pending Fnd 10/13/2007 Fnd 1:00 am 2 Accident Investigation Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 X Suicide Could not be or Town, State) 310 M<u>ansion</u> Dr. Apt 11 Perryville, M determined (Specify) residence Homicide 29a. Certifier 1 Certifying Physician. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the I within 2 and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie October 13, 2007 O.C.M.E. DOME 30. Name and address person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Mary G. Ripple MD Deputy Chief Medical Examiner 13460 32 Registrar's Signature 31. Date filed (Month, Day, Year, State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death

		-	For State Registrar	,,	Ce	rtificate of D	Death	Reg	. No. 200	7 33280
1	0		Decedent's Name (First, Middle, La	st)				Date of Death Month	Day Year	3. Time of Death
	Physicia /Medic			John	n A. Park	cer			Oct 10, 2007	2:15 a ^M
	Examin		4a. Facility Name (If not institution, giv	e street and number)		4b. City, Town, or	Location of Death		4c. County of Deat	h
				Health & Rehabilita				timore		N/A
	Funeral Director		5. Social Security Number 6. S 212-34-2111 Usual Residence of Decedent	Sex 7. Age (In	yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 1	9. Birt Co 1, 1937	hplace (State or Foreign untry) Maryland
	ow at		10a. State 10b. County	10	c. City, Town or Lo	ocation				10d. Inside City Limits
	Mary I-f sh fied	į	Maryland	N/A		1	Baltimore			1 ∐ Y) (s 2 ∐ No
	n the	Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of What Co	ountry?
	er death with the Marylan items 23a or 28a-f show ner must be notified at		2249 Reisterstown R	oad			21217		U	.S.A.
	r dea	Funeral	11. Marital Status	12. Was Decedent Ever Armed Forces?	r in U.S. 13.	Was Decedent of His If Yes, specify Cuba	spanic Origin? (Spe n, Mexican, Puerto	ecity Yes or No- Rican, etc.)	14. Race - Ame Black, Whit	
Baltimore, Maryland 21215-0036	urs aft al", or Exami	þ	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 Yes 2 No If Yes, Give X Year or Dates:		1 □ Yes 2 □ Nox			Specify:	Black
5-0	n 72 ho "natur edical	etec	15. Decedent's E (Specify only highest gr	ducation ade completed)	i (Give	edent's Usual Occupa kind of work done d	urina most of worki	ng I	6b. Kind of Business	Industry
121	within iene. than "	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retired,			Self	Employed
2	iled v Hygie ther t nt, th		17. Father's Name (First, Middle, Las	*)		П	andy Man 18. Mother's Name	(First Middle M	aiden Surname)	
and	d be familiar	Be		n A. Parker				' '	ldine A. Parker	
Ž	should nd Me mark matic	2	19a. Informant's Name/Relationship		19b. Mail	ing Address (Street a	and Number or Rura		City or Town, State, I	
N S	nd 2 salth ar 27 is r trau		Coretta Cain Sister	,		1627 Booker				, ,
ē,	ages 1 and 2 should be filed within ant of Health and Mental Hyghene. It: If item 27 Is marked other than we or other transity or other traumatic event, the Men.		20a. Method of Disposition		20b. Place of Disp				0c. Location - City or	Town, State
Ē	Page nent c nt: if		1 □ B x trial 2 □ Cremation 3 [4 □ Donation 5 □ Other (<i>Speci</i>		•	Mt. Zion Ceme		10/16/07	Lansdow	ne, Maryland
alti	permit. Pag Department Important: i any Injury o	1	21. Service Dice	n w	_	2. Name and Addres				
m	De la la la la la la la la la la la la la		LOUQ 1	11.250	11.	Estep	Brothers Fun Eutaw Place	eral Service,	P. A.	
n			23a. Part1. Enter the disease, or con shock, or hear failure. List only	pplications that caused the one cause on each line.	death. Do not er	ter the mode of dying	g, such as cardiac	or respiratory arre	st,	Approximate Interval Between
	Physician		Immediate Cause Final disease or condition	4.4	_	Concer	1	mind		Onset and Death
4	/Medical Examiner		resulting in death)	Due to (or as a co	onsequence of):		- /			
	Examiner	_	Sequentially list conditions,	b						
7	led sit	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a co	onsequence or):					
1/2	irtificate be executed ng physician and as the burial-transit	Examiner	that initiated events resulting in death) Last	c Due to (or as a co	onsequence of):					
68760,4	be e sician			·						
687	ertificate ing physi e as the l	Medical								
P.O. Box	The law requires that the death cert te has been signed by the attendin.	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome pf p 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at tim 9 ☐ Unknown	Fetal death 3	□Ectopic pregnancy □ Other (specify)			23d. Date of de Month	livery Day Year
٣.	s that ned b deta	by Ph	Part II. Other significant conditions	contributing to death but n	ot resulting in the	underlying cause give	en in Part I.	23e. Did tob	acco use contribute t	o the cause of death?
rds	w requires been sig should be							1 ☐ Ye	s 2 □ No 3 □ P	robably 4 hnknown
Division or Vital Records,	e law re has bee je 2 sho	Completed						24a. Was an autopsy perform	24b. Were a prior to death?	utopsy findings available completion of cause of
a		S		1				1 Yes 2	ZNo 1 ☐ Yes	s 2□No
Ζit	sicial certii recto	Be c	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital:	0 □ □ □ □ □ Outpatio	Othe	26. Place of Deat			
o	Attending Physician: r death. ector: After this certifics by the funeral director. I	٠. T	27. Manper of Death	28a. Date of Injury	2 ER/Outpatie	of 28c. Injury	4 Mursing Ho	me 5 ☐ Hesidei 28d. Describe ho	nce 6 Other (Spe w injury occurred	ecify)
on	th. : After s funer	ţi	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Ye	ear) Injury		<br Yes 2 □ No			
ivisi	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the ft	Certification:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determined		- At home, farm, s Specify)	treet, factory, office		28f. Location (Str. City or Town,	eet and Number or Fi State)	lural Route Number,
	To the Hospitai or within 24 hours afte To the Funeral Dir completely filled in I			hysician: To the best of n						
	the H iin 24 the F	Medical	one)	and manner stated						
	To To	2	29b. Signature and title of certifier	K. Tr.		29c. License		i	d. Date signed (Mon	īn, Day, Year)
				a Kipind	1 mg	0	31865		10111	07
	le		30. Name and address of person who	completed cause of death	h (Item 23a) (Type 41 6	e, Pnnt)			wson mel	21286
	Sta		31. Date filed (Month, Day, Year)	Kizwe 32 Registrar's	Signature	1	,			
	Regist	ar	OCT 1 7 20	Ul Design	S. SEX	Sell of				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. NoZ U [] 7 3328 I Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Day 3 Griffin **Physician** Maggie /Medical 4a. Facility Name (If not institution, street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Sq. uare Franklin HUS PITAL Bultimore Bultoms re Social Security Number If Under 1 Year | If Under 24 Hrs. Sex Age (In yrs. last birthday) Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Days Months 1 □ M 2 □€ 214-20-0790 Director arolina Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits Is marked other than "natural", or Items 23a or 28a-f show aumatic event, <u>the Medical Examiner must be notified at</u> 1 Ses 2 No MD Funeral Director timore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1224 Was Decedent Eve Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No þ Specify 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired) College (1-4or 5+) 18. Mether's Name (First, Middle, Maiden Surname) Be 551 e ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City of Town, permit. Pages 1 and 2 s Department of Health ar Important: If Item 27 Is any Injury or other trau once. iece Place of Disposition (Name of cemetery, crematory or other place, 2 Cremation 3 Removal from State 5 Other (Specify) 4 □ Donation 21. Signature of Funeral Service Licensee LU: 10 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dv shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Sepsis /Medical Due to (or as a consequence of) Infarction Examiner Myocard Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed Dementia attending physician and for use as the burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4☐Pregnant at time of death 5 Other (specify) been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown certificate has b irector, page 2 sh 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No autopsy performed To the Hospital or Attending Physician: I director, 25. Was case referred to medical Be 26. Place of Death (Check only one, examiner? Hospital: 1 mpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) ို 1 Yes 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and due to the cause(s) and manner as stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number D006190 completed cause of death (Item 23a) (Type, Print) Name and address of person who nukwuma 124 Mac Avenue 31. Date filed (Month, Day, Year) 32 Registrar's Signatur State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 14, 2007 Philip Vincent Pierorazio October 14:40 p. 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Harford Upper Chesapeake Medical Center Bel Air If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday Days Hours Months Min 1**X** M 2□ F 218**-**48**-**0154 60 Nov. 18, 1946 Maryland Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2 No Maryland Harford Jarrettsville 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? 1909 Furnace Road 21084 United States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 X Yes 2 No If Yes, Give Year or Dates: Vietnam 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) +6 Systems Engineer Defense 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Michael Pierorazio Rose D'Ulisse 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael A. Pierorazio (Son) 8717 Melissa Lillian Court Nottingham, Md. 21236 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 Removal from State 10/18/07 4 ☐Donation 5 ☐ Other (Specify) Oak Lawn Cemetery Baltimore, Maryland 22. Name and Address of Facility 21. Signatur of Ameral Service Licensee Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Avenue Dundalk, Maryland 21222 sease, o complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, this only one cause on each line. 23a. Part1. Enter the Asea shock, or heart failure Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CANCER PANCREATIC Due to (or as a consequence of) CARDIAC ARREST Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initialed events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💥 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autops, performed 2 X No 1∐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No 1 Yes 1 Inpatient 2XER/Outpatient 3 □ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Natural

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

28a-f show

Director

Funeral

δ

Completed

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permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at

1 and 2 should be fill Health and Mental H tem 27 is marked oth

timore, Maryland 21215-003

burial-transi Physician/Medical for detached been signed by should be detact Completed page 2 s certificate has 2 this Certification:

completely filled in by the funeral

To the Hospital or Attendl within 24 hours after death. To the Funeral Director: A 10+1

State Registrar

Medical

and manner stated.

5 ☐ Pending investigation

6 Could not be

2 ☐ Accident

3 Suicide

29a, Certifier

4 Homicide

29b. Signature and title of certifier

Place of injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

Excertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, In my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year) 2007

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

mo 500 upper Chesaplake Dr. Bel Air, MD 24014 Bentman

31. Date filed (Month, Day, Year)

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 33283 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** October 12, 2007 Sharon Ann Punte 2:36 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b City Town or Location of Death Examiner Howard County General Hospital Howard Columbia If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, NOV . 1, 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Year) 47 1 □ M 2 X F 59 MaryTand 216-48-4735 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 7 is marked other than "natural", or Items 23a or 28a-f show traumatic event, <u>the Medical Examiner must be notifiled at</u> 1 ☐ Yes 2X No Columbia MD Director Howard e filed within 72 hours after death with the I al Hygiene. other than "natural", or items 23a or 28a-10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21046 9510 Footprint Place USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc. 1 □ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Teacher Howard Co. School Syst. 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy important: If Item 27 is marked othe any Injury or other traumatic event, 17. Father's Name (First, Middle, Last) Be Catherine Redell Harry Sloan 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Mr. Bernard Punte / Husband 9510 Footprint Place Columbia, MD 21046 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Murial 2 ☐ Cremation 3 ☐ Removal from State Sacred Heart of Jesus 10/17/2007 Dundalk, MD 4 ☐ Donation 5 ☐ Other (Specify) 5305 Harford Rd. 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Kimberly Davidson Baltimore, MD 21214 Leonard J. Ruck, Inc. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ACUTE Physician PULMONARY disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner burial-transi certificate be execu and resulting in death) Last Due to (or as a consequence of): iding physician se as the burial Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant atten 3 Ectopic pregnancy Month Year in the past 12 months? 4□Pregnant at time of death 5 Other (specify) signed by the a d be detached for P.O. P 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown CONGESTIVE HEART FAILURE Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an page 2 s autopsy To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 28a. Date of Injury 27. Manner of Death 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural (Month, Day Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 4 ☐ Homicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of ce D36373 ompleted cause of death (Item 23a) (Type, Print) 3449 Wilkers for BACTITORS 170 21229 32 Registrar's Signature 31. Date filed (Month, Day, Year, State OCT 1 7 2007 a sur Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** Charles Patrick Ouattrocche 15. 2007 October 7:15 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Manor Care Health Services-Rossville Rosedale <u>Baltimore</u> If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 07/26/1923 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1**½** M 2□ F 84 Director 216-16-6594 Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examina. 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2 No Director Maryland Baltimore Essex 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3 Valley Arbor Court Apt. 21221 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1.0.4 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: White Completed by 3 Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Produce Manager Grocery Store 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Joseph Quattrocche ပ Mary Pistoria 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wayne Joseph Quattrocche- Son 7 Mango Trail Middle River, Maryland 21220 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Parkwood Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 10/17/2007 | Baltimore, Maryland 22. Name and Address of Facility Bruzdzinski Funeral Home P.A. 21. Signature of Funeral Service Licensee 1407 Old Eastern Avenue Essex, Maryland 21221 Lichael 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) metar **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner that the death certificate be executed Due to (or as a consequence of): attending physician a for use as the burial-Physician/Medica! 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1☐Yes 2☐No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown signed by be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy perform 1 Yes 2 certificate the Hospital or Attending Physician: hin 24 hours after death. 25. Was case referred to medical examiner? director, Be 26. Place of Death (Check only one) Hospital: Other: 4 Worsing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA 10 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t Medical Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No To the Hospital or Attendil within 24 hours after death. To the Funeral Director: A completely filled in by the fu 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) ZVAn DBIYLY

Box 68760

P.O.

Records,

Division or Vital

State Registrar 82 IN EUTAN ST

32 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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2007

31. Date filed (Month, Day, Year)

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State Registrar

DR. TARIQ MAHMOOD 31. Date filed (Month, Day, Year)

OCT 1 7 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifie

2300 DULANEY VALLEY RD. 32. Registrar's Signature

2007

OCTOBER 12,

BETTINA ROBEY

29c. License number

TIMONIUM, MD 21093

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TTEM#10e per FH G872 10/17/07 WS
State of Maryland Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Physician RUTH 8:35 PM RICHARDSON OCTOBER 2007 /Medical 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner BALTIMORE Inder 1 Year | If Under 24 Hrs HARBOR HOSPITA 5. Social Security Number UNK 6. Sex 7. Age (In yrs. last birthday) If Under 1 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Days Hours 1 □ M 25€F 216-30-059 MARYLAND Feb. Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County Pages 1 and 2 should be filed within 72 hours after death with the Marylanment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at Yes 2 No **Funeral Director** RALTIMORE MD 10e. Street and Number Maisel 10g. Citizen of What Country? 21230 FD STATES

Race - American Indian,
Black, White, etc. INII EP 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 Yes, Give Year or Dates: 1 Never Married 2 Married 1□Yes '⊅**⊠N**o Specify þ BLACK 3 ☐ Widowed 4 ☐ Divorced Be Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) SERVER FOOD SERVICE UNK 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ESSI E PRICE HOWARD FAULCON 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) FALCON HARRIS 20b. Place of Disposition (Name of cemetery, crematory or other place) COTTAGE BALTO, MD 20c. Location - City or Town, State VALARIE Baltimore, 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Department of Important: If it any injury or conce. MEMORIAL 10/22/07 WODDLAWN MD 22. Name and Address of Facility Miller's Metropolitary Chinal KINGS MEMORIAL! 21. Signature of Francial Service Licent BROADWAY BALTO, MD 21213 1639 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 3YEAR ? LYMPHOCYTIC LEUKEMIA **Physician** HRONIC /Medical Due to (or as a consequence of): Examiner 6MONTHS ETASTATIC INFLAMMATCH Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-trai Due to (or as a consequence of) physician Physician/Medical the attending p 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) P.0. the 9□Unknown 9 Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown MYOCARDIAL INFARCTI Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No DSTEDARTHRITI 24a. Was an autopsy performed 1∐ Yes 2VINO 25. Was case referred to medical examiner? 26. Place of Death Check onl one Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 | Yes 2 | No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28h Time of 27. Manner of Death 28c. Injury at Work? Certification: To the Hospital or Attending I within 24 hours after death.

To the Funeral Director: After Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide Tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier RESOOO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BALTIMORE. BAM S. HANOVER STREET. 32 Registrar's Signature 31. Date filed (Month, Day, Year) **OCT 1** 7 2007 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland bepartment of Health and Mental Hygiene

2007 33288

			1 - For State Registrar	State of Ma	Ce.	rtificate of		Re	g. No. 2007	33288	
	Physici	an	1. Decedent's Name (First, Middle, Last,					2. Date of Death Month		3. Time of Death	
· dept	/Medic		Catherine	Denise	Rodgers	T		October	15, 2007	10:28a. M	
>	Examin	er	4a. Facility Name (If not institution, give				Location of Death		4c. County of Deat	h	
	Funeral	_	717 N. Caroline 5. Social Security Number 6. Sec		(In yrs. last birthday)		If Under 24 Hrs.	8. Date of Birth (Month, Day,	N/A 9. Birtl	hplace (State or Foreign	
÷	Director		217-80-5558]м 2ДГ	47 Yrs.	Months Days	Hours Min.			uintry) NJ	
	yland at		10a. State 10b. County		10c. City, Town or Lo					10d. Inside City Limits	
	e Mar la-f sl	ctor	MD N/A		Baltim	ore				1 Yes 2 No	
	or 28	Dire	10e. Street and Number			10f. Zip Code		10	g. Citizen of What Co	untry?	
	s 23a nust	eral	717 N. Caroline	Street 12. Was Decedent Ev	var in II S 12	Was Decedent of H		agifu Van ar Na	USA 14. Race - Amer	rican Indian	
	fter der ritem	Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married	Armed Forces?		Was Decedent of H If Yes, specify Cuba	an, Mexican, Puerto	Rican, etc.)	Black, White		
036	ursa al", o Exam	by	3 ☐ Widowed 4 X Divorced	If Yes, Give Year or Dates:		1 □ Yes ¾ No	Specify:		Specify:	Black	
21215-0036	filed within 72 hours after death with the Maryland Hygiene. htter than "natural", or items 23a or 28a-f show ent, the Medical Examiner must be notified at	Completed	15. Decedent's Edu (Specify only highest grad	cation e completed)	i (Give	dent's Usual Occup	during most of work	ding I	6b. Kind of Business/l	ndustry	
121	within sne. than '	dm	Elementary/Secondary (0-12)	College (1-4or 5+)	DO NOT use retired			1-		
	filed v Hygie ther i	ပ္ပိ	12th 17. Father's Name (First, Middle, Last)	N/A	u	nemployed		e (First, Middle, M	N/A faiden Surname)		
Maryland	lid be lental ked o ic eve	To Be	Dennis Mack	Tyson			Patrio	cia	Harpe	r	
ary	shou and M s mar	-	19a. Informant's Name/Relationship (Ty		19b. Maili	ng Address (Street			City or Town, State, Z		
	and 2 ealth a		Patricia Foster-m	other		E. Eager		Baltimore	e, MD 212	205	
ore	jes 1 t of Hi lf iten or oth		20a. Method of Disposition 1 ★ Burial 2 ☐ Cremation 3 ☐ F	emoval from State	20b. Place of Dispo cemetery, cre				20c. Location - City or		
Baltimore,	t. Pag tmen tant: tant:		4 ☐ Donation 5 ☐ Other (Specify)			Cemetery		20/07	Baltimore	e MD	
Bal	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at one.		21. Signature of Funeral Service Licens	wan	2	2. Name and Addre	ss of Facility MA	ARCH FUNE	RAL HOME-E	CAST	
	_	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.									
	Physician ¹		shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition a. Myocodia Inforction								
r	/Medical		resulting in death)	Due t (or as a	consequence of):	1 year cho	2				
	Examiner		Sequentially list conditions),							
1	po #is	iner	if any, leading to immediate		consequence of):						
r	xecute and Il-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a	consequence of):						
68760,	rificate be executed of physician and as the burial-transit										
89	ificate g phy: as the	edical									
Box		M/us	200. Was decedent pregnant	3c. If yes, outcome p		Tectonic pregnancy	,		23d. Date of deli	ivery	
В	The law requires that the death cer te has i een signed by the attendir age 2 should be detached for use	Physician/N	1 ☐ Yes 2 X No								
P.O.	hat the d by t fetach	Phy	9 ☐ Unknown Part II. Other significant conditions con		not resulting in the u	nderhina cause aiv	on in Part I	23a Did tob	acco use contribute to	the cause of death?	
ds,	signe d be c	by	Takin oner signmean conditions con	imbaling to death but	not resulting in the u	ndenying cause givi	en in Fait i.	1 ☐ Ye	1/	obably 4 □Unknown	
Sor	requirements	ompleted						24a. Was an		topsy findings available	
Re	The larte has age 2	dmo						autops) perform	prior to death?	completion of cause of	
ta	- W	Be Co	25. Was case referred to medical				26. Place of Deat	1 Yes 2 h (Check only one	No 1 ☐ Yes	2 No	
>	Physiclan: r this certific ral director,	To B	examiner? 1 ☐ Yes 2 No	lospital: 1 Inpatient	t 2 ER/Outpatier	nt 3 DOA Oth			nce 6 □Other (Spec	cify)	
ם ס	Ing PI	ou:	27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Injury (Month, Day	Year) 28b. Time o	Worl	k?	28d. Describe hor	w injury occurred		
Sio	Attending It death. ector; After by the fune	cati	2 Accident investigation 3 Suicide 6 Could not be	OGo Diego of injur	At home form at		Yes 2 □ No	006 1 (04-			
Division or Vital Records,	l or Ai after c Direc	Certification:	4 ☐ Homicide determined	building, etc.	y - At home, farm, sti (Specify)	eet, ractory, office		City or Town,	eet and Number or Ru , State)	iral Houte Number,	
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Medical C	29a. Certifier 1 Certifying Physical (Check only one) 1 Medical Exami	ner: On the basis of e	examination and/or in	h occurred at the tir	me, date and place, ppinion, death occur	and due to the ca	use(s) and manner as ate and place, and due	stated. to the cause(s)	
	o the ithin 2 o the o the o the omple	Med	29b. Signature and title of certifier	and manner state	ea.	29c. Licens	e number	29	9d. Date signed (Monti	h. Dav. Year)	
	F≯Fö		M.18.	b Olia	MD		57237	-	- '		
,	,	1	30. Name an address of person who co	impleted cause of dea			- , 2 5 ,		16, chber 16,	100	
_	2		Gail Berkenblin		Caroline		Itimore 1	3515 61	37		
	Sta		31. Date filed (Month, Day, Year)	32. Registrar	's Signature	. A.					
	Registr	ar	OCT 1 7 20	107 Lines	JS 15	and I					

			1 - For State of Maryland / State of Maryland /	•	ment of He ficate of E			ene 2007	33289
	Physici	an	Decedent's Name (First, Middle, Last) Virginia B. Rybicki				2. Date of Death Month	Day Year	3. Time of Death
	/Medio Examin		4a. Facility Name (If not institution, give street and number) Genesis Health Care College View		o. City, Town, or Frede	Location of Death	october	13, 2007 4c. County of Death Frederi	4:20 P
	Funeral Director		5. Social Security Number 236–36–1928 6. Sex 1 □ M 2 ▼ 7. Age (In yrs. last to 10 M 2 ▼ 82		Under 1 Year lonths Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 09/03/1		hplace (State or Foreign untry) t Virginia
	aryland show	L.		own or Location	Frederi	ck			10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	n the Ma or 28a-f	Director	Maryland Frederick 10e. Street and Number		10f. Zip Code		10	Og. Citizen of What Co	
	leath wit	Funeral D	548 Logan Street 11. Marital Status 12. Was Decedent Ever in U.S.	13. Was	217		ecity Yes or No-	U.S.A.	rican Indian,
900	d within 72 hours after death with the Maryland jiene. Ir than "natural", or iteme 23a or 28a-f ehow Ir a Medical Examinar must be notified at	by	Armed Forces? 1 Never Married 2 Married I Yes 2 No If Yes, Give Year or Dates:		es, specify Cubar Yes 212 No	spanic Origin? (Sp n, Mexican, Puerto Specify:	Rican, etc.)	Black, White	e, etc.
21215-0036	within 72 h ene. than "natu	Completed	(Specify only highest grade completed) Elementary/Secondary (0·12) College (1·4or 5+)	(Give kind life. DO	NOT use retired)	uring most of work	ing	Manufactus	
1d 2	il Hygid other	Be Co	11 17. Father's Name (First, Middle, Last)	Asser		e Worker	e (First, Middle, M	-	1119
Maryland	should by	To	Louis Tasker 19a. tnformant's Name/Relationship (Type, Print) 19	9h Mailing A	Address (Street a	Nelli		City or Town, State, 2	?in Code)
	nd 2 still ar ar ar ar ar ar ar ar ar ar ar ar ar		Dennis Rawlings - Son	548 L	ogan Str	eet Fre	derick,	Maryland 2	1701
more	Pages 1 a ent of Hes nt: if item ry or othe				on (Name of ory or other place • Memori			Elkridge,	
Baltimore,	permit. Pages Department of I Important: If Ite any Injury or of once.		21. Signature of Funeral Service Licensee	22. Na	ame and Address	s of Facility Br	uzdzinsk	i Funeral Ssex, Mary	Home P.A.
			23a. Part 1. Enter the disease or complications that caused the death. De shock, or heart failure. List only one cause on each line.	o not enter th	he mode of dying				Approximate Interval Between Onset and Death
	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death) a. Cardib My Due to (or as a consequence)	te of):	hy				
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6	ate be executed hysicien end the burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last C. Due to (or as a consequence)	ce of):					
68760,	icate be physicie s the bu	edical	d						
.O. Box (that the death certifica ted by the ettending ph detached for use as t	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetel dea 4 □ Pregnant at time of death 9 □ Unknown	ath 3 □Ect	topic pregnancy ther (specify)			23d. Date of del Month	ivery Day Year
Δ.	quires that I n signed by uld be deta	ρ	Part II. Other significent conditions contributing to death but not resulting	g in the unde	rlying cause give	n in Part I.	23e. Did tob	pacco use contribute to	the cause of death?
Division of Vital Records,	The law requires that site hes been signed b page 2 should be deta	Completed	Congestive Heart F	ailu	re		24a. Was ar autops perform 1 Yes 2	y prior to death?	llopsy findings available completion of cause of 2 No
Vita	sician: certific irector.	To Be (25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/C	Outpatient	Otho	26. Place of Deat		e) ince 6 Other (Spe	Coffe)
on of	fer fer and		27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b	b. Time of Injury	28c. Injury Work	at ?		w injury occurred	ony)
Divisio	To the Hospital or Attending within 24 hours after death. To the Funeral Director: Attencompletely filled in by the fune	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, building, etc. (Specify)			′es 2□No	28f. Location (St. City or Town	reet and Number or Ru n, State)	ural Route Number,
	ne Hospita 124 hours 16 Funeral	edical C	29a. Certifier (Check only one) Certifying Physicien: To the best of my knowled and manner stated.	dge, death oc and/or invest	ccurred at the time tigation, in my op	e, date and place, inion, death occur	and due to the ca red at the time, da	ause(s) and manner as ate and place, and due	stated. to the cause(s)
	To the To the Comp	M	29b. Signature and title of certifier		29c. License			9d. Date signed (Mpnt	
,	81		30. Name and address of person who completed cause of death (Item 23a	a) (Type, Prir	1000	on Dr		10/13/2	2(70)
	Sta	te	31 Date filed (Month, Day, Year) Begistrar's Signature	mas		on Dr	. tred	erice i	10
	Registr		OCT 1 7 2007	Granic	المر				

			State of Maryland / Department of Health and	Mental Hyg	iene 2 N	07	33290
			Registrar Certificate Of Death	2. Date of Deat	∌g. №0.		3. Time of Death
	Physici	an	1. Decedent's Name (First, Middle, Last) ALYSE STOKES	Month	Day	Year	9:35 A M
`	/Medic		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deat	h	4c. County		
	Examin	ier	110 N. CENTRAL AVE, ADT 325 BALTIMORE				
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs	8. Date of Birth	Year)	9. Birthpl Count	ace (State or Foreign
	Director		213-34-3454 1 M 2) TF 74 Yrs. Months Days Hours Min.	Sept. 2,1	1933	NOR	TH CAROLINA
	pu 🛦		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location	/ /		10	Od. Inside City Limits
	Aaryli sho	ō					Yes 2□No
	h the Marylan r 28a-f show	Director	10e. Street and Number 10f. Zip Code	1	0g. Citizen of \	What Count	try?
	deeth with the Maryland ms 23e or 28e-f show Littust be notified at		110 N. CENTRAL AVE. Apt #225 21202	1	WITED	< T21T	F<
		Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (S. If Yes, specify Cuban, Mexican, Puer	pecify Yes or No-	14. Rac	e - America	
٥	or its		1 Never Married 2 Married 1 Yes No	o rican, etc.)	Specifi		a. 10
2-003e	hours after tural', or ite al Examine	d by	3 ☐ Widowed 4 ☐ Divorced Year or Dates:	}		BLA	RK.
<u>ဂ</u>	within 72 ene. than "nat he Medica	Completed	15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of wo life, DO NOT use retired)		16b. Kind of B	usiness/ind	ustry
7	with lene.	E O	Elementary/Secondary (0-12) College (1-4or 5+) HOUSE KEEPER		DOME	571	C.
0	other ent,	Be C		me (First, Middle, I			
land	uld be Mental irked c	To E	OSCAR CHEEK INE	Z PIN	WIX		
Mary	2 should and Men Is marke aumatic		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Re		•	•	
	s 1 and 2 shou f Health and M Itam 27 Is mar other traumat		HERGER LEE THURMAN 110N, CENTRAL AVI				
<u> </u>	Pages 1 nent of H int: If ita iry or otl		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)		20c. Location	•	
altimore,			4 Donation 5 Other (Specify) 21. Signature of Finital Service Lightness 22. Name and Address of Facility M	14,2087	BALTO	MI	2 1 1 1 1 1 1 1 1 1 1 1 1
g R	permit. Departe importe any in		21. Signature of Parallel Service Ligensee 22. Name and Address of Pacifity M				
			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardia			اس اس	Approximate
	Den elejan		shock, or heart failure. List only one cause on each line. Immediate Cause (Final	= 2			Interval Between Onset and Death
1	Pnysician /Medical		disease or condition resulting in death) A Due to (or as a consequence of):				
	Examiner		Sequentially list conditions				
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D	ecute and -trans	Examiner	Cause (Disease or injury that initiated events c				
S S	The law requires that the death certificate be executed the bas been signed by the attending physiclen and page 2 should be detached for use as the burial-transity.						
2	ificate physis the	edical	0.				
žog	eath certifi attending p I for use as	lan/Me	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy		23d. Da	te of delive	ry
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r Ö	res thet the de signed by the a I be detached f	by Physici	3 C OUKUOWU				
	res th signed be d		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	1	acco use con		e cause of death? ably 4 □Unknown
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	ysicism: is certific director,	o B	examiner?	ath (Check only on Iome 5 Reside		er (Specifi	,
ō	g Physical this seral di	T ic	27. Mannyr of Death 28a. Date of Injury 28b. Time of 28c. Injury at	28d. Describe ho			,
<u></u>	andin ath. or: Aft	atlo	2 Accident investigation M 1 Yes 2 No				
DIVISION OF	r Atter de l'ecte	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (St City or Town		oer or Rura	Route Number,
	Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certific tely filled in by the funeral director.						
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical	29a. Certifier (Check only one) 1.□ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place (Check only one) 1.□ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place (Check only one)	a, and due to the caurred at the time, d	ause(s) and ma ate and place,	anner as st and due to	ated. the cause(s)
	o the	Med		2	9d. Date signe	d (Month, L	Day, Year)
)	⊢ s ⊢ ō		DIGGIA	6	Octob	en 1,	1, 2007
	6		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)		0 4 1 1		,
	5		29b. Signature and title of certifier D16619 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) C. VERGARA - SCARES GG40 FRANKLIN SOUARS 31. Date filed (Month, Day, Year) OCT 1 7 2007 32. Registrar's Signature	E DR. 1	OALTIR	WAE,	MD. 21236
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Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Aortic Dissection Hypertension 24a. Was an autopsy performed? Injury of the examiner? 1 Yes 2 No 3 Probably 4 4 Aurity 4 Aurity 4 Aurity 4 Aurity 4 25. Was case referred to medical examiner? 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical examiner? 1 Yes 2 No 1 Yes 2 No 26. Place of Death (Check only one) 27. Manner of Death 1 Was an autopsy performed? Injury of the examiner of the e	d for	in the past 12 months? in the past 12 months? 1								Month	Day Year					
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Aortic Dissection 1 Yes 2 No 3 Probably 4	y P	Part it. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23e. Did tobacco use contribute to			the cause of death?				
Hypertension 24a. Was an autopsy finding prior to completion of death? 1 Yes 2 No 25. Was case referred to medical examiner? 1 Yes 2 No 25. Was case referred to medical examiner? 1 Yes 2 No 25. Was case referred to medical examiner? 1 Yes 2 No 26. Place of Death (Check only one) 27. Manner of Death 1 Natural 5 Pending investigation 3 Suicide 4 Homicide 28a. Date of Injury 28b. Time of Injury 28b. Ti	uld bi									No 3□Pro	ebably 4 □Unknown					
autopsy performed?	s bee	Hypertension 24a. Was an								24b. Were autopsy findings ava						
25. Was case referred to medical examiner? 1	age age	autopsy performed?								death?						
examiner? Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)	or, p									26 Place	of Death			1 1 105	2 L3 NO	
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1 Strikatural 5 Pending investigation 2 Accident 3 Suicide 4 Homicide determined 2 Be. Place of Injury - At home, farm, street, factory, office 2 No 28f. Location (Street and Number or Rural Route No. City or Town, State)	er thi	.		28a. Date	of Injury	:	28b. Time of		-							
3 Suicide 3 Suicide 4 Homicide 4	e fun			2.011	nin, Day 1	(ear)	injury				No					
Sign of the state	by th		4-4	289. Plac				eet, factory,	office					lumber or Ru	ral Route Number,	
7 7 7	d in in		4 Nomicide	Duile	aing, etc.	(Зреспу)	,					City or Town, State)				
29a. Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause	unera aly fille cai (29a. Certifier t Certifying Pl	nysicien: To the	e best of	my know	vledge, death	occurred a	t the tim	e, date an	d place,	and due to the	cause(s) an	d manner as	stated.	
29a. Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and titlefof certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause and due to the cause and manner as stated. 29c. License number 29d. Date signed (Month Day Year	plett		one)	and mai	nner state	id.										
29b. Signature and titlegof certifier ATTEMBING 29c. License number 29d. Date signed (Month, Day, Year, D34740 10-15-2007	5 6		29b. Signature and titlerof contifier	ILAN			•							-		
/ TATOLINE	1	+	, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	3 4 - /											•	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Robert Fields, MD 18109 Prince Philip Drive Olpey MD 20222	a															
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Registral III. 1 7 2007	State Registrar		31. Date filed (Month, Day, Year)	32.	Registrar'	s Signati	ure	8		OIII	ey,	MD 2003	0.2			
Registrar 0CT 1 7 2007 1 17 2007	State Registrar		31. Date filed (Month, Day, Year)	32.	Registrar'	s Signati	ure	(Aug		OIII		MD 2083				

DHMH 17 Rev 1/2001

			For State	State	of Mar	yland / Dep Ce	artmen	t of H e of L	ealth a Death	ind M	ental Hyg	giene	200	7	33292
t.			Registrar 1. Decedent's Name (First, Middle,	Last)			Timoat	0 0, 2			2. Date of Dea	ath			3. Time of Death
	Physicia /Medic	_	Helen Mari	e Ship			_				Oct.	Day		7	2:20 p ^M
	Examin	er	4a. Facility Name (If not institution,	-	number)		1		Location of		4c. County of Death Carroll				
			1044 Bird Hi 5. Social Security Number	II Dr.	7 Age (In yrs. last birthday		1 Year	minst		8. Date of Birtl				ce (State or Foreign
4	Funeral Director		216-05-1687	1□M ¾ □F		Yrs.	Months	Days	Hours	Min.	OCT. Day	5 / Year)	912 1		yland
	ס		Usual Residence of Decedent												
	show dat	_	10a. State 10b. County Maryland Car	roll	1	Westmin								10d	. Inside City Limits 1 ☐ Yes 2 XNo
	Ba-f :	ecto				MESCHIT						10 0"			
	a or 2	Ē	10e. Street and Number 1044 Bird Hil	1 Dr			10f. Zip	115	7			10g. Citt	zen of What (U . S . i		· ·
	ns 23	Funeral Director	11. Marital Status	12. Was De	ecedent Ev	er in U.S. 13			•	in? (Spe	cify Yes or No- Rican, etc.)		14. Race - An	nerican	
ဖွ	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f show aumatic event, the Medical Examiner must be notified at	Fun	1 ☐ Never Married 2 ☐ Marrie		Forces? s 2 X No		If Yes, special of Yes		n, Mexican Specify:	, Puerto I	Rican, etc.)		Black, WI		
Maryland 21215-0036	ıours ıral",	d by	3 XWidowed 4 ☐ Divorced	Year or	r Dates:									√hi	
<u></u>	"nati	Completed	15. Decedent's (Specify only highest		ed)	16a. Dec	edent's Usua e kind of wo DO NOT us	al Occupa rk done d se retired	ation <i>luring most</i>)	of workir	ng	16b. Ki	nd of Busines	is/Indus	stry
12	within iene.	dmo	Elementary/Secondary (0-12)	College	e (1-4or 5+)		les						Sale	28	
g	illed I Hyg other	Be C	17. Father's Name (First, Middle, L	ast)						r's Name	(First, Middle,	Maiden			
lan	uld be Aenta rked tic ev	To B	Edward Yo	X					Gra	ace	Elizak	oeth	Poe		
ary	01 (0) 47 (11		19a. Informant's Name/Relationshi	p (Type. Print)			-				l Route Numbe	-			
	1 and 2 Health tem 27 i		James B. Woo	<u>d - god</u>	dson										21157
altimore,	it of H		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City of cemetery, crematory or other place) 20c. Location - City of cemetery, crematory or other place)												
<u>=</u>	it. Pa rtmen rtant: njury		4 Donation 5 Other (Specify) Evergreen Mem. Gardens Finksb									-			
Ba	permit. Pages 1 an Department of Heal Important: If item 2 any injury or other once.		21. Signature of Fugeral Service Licensee 22. Name and Address of Facility Ckhardt Funeral Class and Address of Facility Ckhardt Funeral Class and Address of Facility Ckhardt Funeral Class and Address of Facility Ckhardt Funeral Class and Address of Facility Ckhardt Funeral Class and Address of Facility Ckhardt Funeral Class and Address of Facility Ckhardt Funeral Class and Address of Facility Ckhardt Funeral Class and Address of Facility Ckhardt Funeral Class and Address of Facility Ckhardt Funeral Class and Address of Facility Ckhardt Funeral Class and Address of Facility Ckhardt Funeral Class and Address of Facility Ckhardt Funeral Class and Address of Facility Ckhardt Funeral Class and Address of Facility Ckhardt Funeral Class and Address of Facility Ckhardt Funeral Class and Facility Ckhardt Funeral Clas												
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition)									A Ir	pproximate nterval Between		
1	Physician		Immediate Cause (Final disease or condition	a C	HRO	VIC TE	MI	FAI	WR	-				2	Onset and Death
	/Medical Examiner		resulting in death)	Due	to (or as a	consequence of):									(
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W	nsit	mine	Sequentially list conditions, it can be cause. Enter Underlying Cause (Disease or injury that initiated events			,									
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Box	eath certific attending p	ian/I	23b. Was decedent pregnant in the past 12 months?		e birth 2	Fetal death 3	□Ectopic p						23d. Date of o Month	, , ,	ay Year
0	The law requires that the death certific tte has been signed by the attending p page 2 should be detached for use as	ysic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown 9								~				
۵.	that t led by detac										se contribute	to the	cause of death?		
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000	aw re	Completed									24a. Was		24b. Were	autops	y findings available
Ä	The lav	omo									autor perfo 1□ Yes	rmed? 2 No	death	?	□ No
ita	slan; ertifica ctor, p	Be C	25. Was case referred to medical examiner?						26. Place	of Death	(Check only o				
<u>></u>	Physician: The la r this certificate has ral director, page 2	မှ	1 Yes 2 No		☐ Inpatient				4 LI INU		ne 5 Resid			pecify)	
n c	ing F	ion:	27, Manner of Death 1 Natural 5 ☐ Pending	(M	ate of Injury Ionth, Day	Year) 28b. Time Injury		28c. Injun Work	yat <br Yes 2∐t		28d. Describe I	now injui	y occurred		
Division or	or Attending after death. Director: After in by the funer	licat	2 Accident investigation 3 Suicide 6 Could not determine		ace of injury	y - At home, farm, s (Specify)			103 2 🔲		28f. Location (5	Street an	d Number or	Rural F	Route Number,
<u>≥</u> .	al or A s after I Dire	Certification:	4 ☐ Homicide determin	bu bu	uilding, etc.	(Specify)					City or Tov	vn, State)		
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director,	edical C		examiner: On the	e basis of e	my knowledge, de examination and/or									
	To the within 2 To the comple	Med	one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Yea.									ay, Year)			
\			1 Karr	0 K. (500	Witter		123	166	G		101	16/2	-CC	(2
	6		30. Name and address of person v		ause of dea	ath (Item 23a) (Type	e, Print)								
			THOMAS K.	GALVI	NI	- mo 2	71 57	me	RA	JUNIL	ie u	2821	12-11 MIN-127	re	maulm'
	Sta Registi		31. Date filed (Month, Day, Year) OCT 1 7	2007	Registrar	's Signature	134K)								

DHMH 17 Rev 1/2001

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State of Maryland / Department of Health and Mental Hydiene

erine Elizabe	1.	For State	of Maryland / Depa	artment of Hea rtificate of Dea	ith and Mental	Reg. 1	200	7 332	
Physiciar	1/	Decedent's Name (First, Middle,Las		<u> </u>		2. Date of Death Month Da October 14, 2		Time of Death	
lical Examin		Catherine E. a. Facility Name (if not institution, given	Stapf re street and number)	4b. City	, Town, or Location of De		4c. County of Death		
		12612 Eastern Avenue			dle River	U- In Date of Birth/A	Baltimore Coun MM/DD/YYYY) 9. Birthp	·	
Funeral Director				ast birthday) If Ur 63 Yrs. Mor	ths Days Hours	Min. Jan. 24	Foreign	MD	
my	_	Usual Residence of Decedent Oa. State 10b. County	,	, Town or Location			1	10d. Inside City Limits	
and show a	٦	MD Baltim	ore Mi	ddle River				1 Yes 2 No	
Baltimore, MID 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Director	Oe. Street and Number 12612 Eastern A	ve.	2	Zip Code 1220		10g. Citizen of What Country? USA		
th with	uneral	11. Marital Status 1 Never Married 2 Marrie	12. Was Decedent Ever in U Armed Forces?	J.S. 13. Was Dece If Yes, spe	edent of Hispanic Origin? ecify Cuban, Mexican, Pu	(Specify Yes or No- erto Rican, etc.)	14. Race - America White, etc.	an Indian, Black,	
ter deal	ഥ		1 Yes 2 No	1 Yes	2X No specify:		Specify: Whi	te	
ours aft atural	d b	15. Decedent's Education (Specify of	or Dates:	16a. Decedent's Usu	al Occupation (Give kind		6b. Kind of Business/In	dustry	
n 72 hc	ompleted	Elementary/Secondary (0-12)	College (1-4 or 5+)	Homemak			Own home		
d withing giene.	탉	17. Father's Name (First, Middle, Las	t)			lame (First, Middle, Ma			
215 be file ntal Hy rked o	8	Joseph Auburge	r			erine Widn		Zin Code)	
2 21 Should and Me	۴	19a. Informant's Name/Relationship Mr. Terry Stapf			ess (Street and Number Eastern Ave				
t, MI and 2 s lealth a tem 27 traum	-	20a. Method of Disposition	20b	Place of Disposition (Name of cemetery,	Date 2	20c. Location - City or	Fown, State	
ages 1 nt of H nt: If i		1 Burial 2 X Cremation 3	Removal from State Hi	.lltop Serv	ice Corp. 1	0/17/2007	Towson, MD)	
altin mit. P partme portan ury or	Ì	4 Donation 5 Other Special 21. Signature of Funeral Service Lice	ensee		and Address of Facility		5305 Harfor	d Rd.	
W FEET		23a. Part I. Enter the disease, or con	book XC	th. Do not enter the mo	onard J. Ru		Baltimore,	Approximate Interva	
Physician Madical		failure. List only one cause on	each line. a. Contact Gunshot Wou		30 0, c)g, see as see	,		Between Onset and Death	
xaminer		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a consequence						
		Sequentially list conditions,	b	of):					
	nine	if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a consequence	OI).			8		
ited d ansit	Examiner	(Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence d.	of):					
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760, icate be physici the buri	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcome of pre		eth 3 Ectopic p	regnancy	23d. Date of delivery	oay Year	
Box 6876(e death certificate the attending phy ed for use as the t		past 12 months?	4 Pregnant at time of						
	hysi	1 Yes 2 No 9 Unkno	9 DIKIOWII	t reculting in the under	ving cause given in Part	I. 23e. Did tob	pacco use contribute to	the cause of death?	
that th	by P	Part II. Other significant condition	s contributing to death but no	it resulting in the under	ying dadad given iir i acc		2 No 3 Prot		
Division of Vital Records, P.O. Box 6876 ral or Attending Physician: The law requires that the death certificate is after death. al Director: After this certificate has been signed by the attending phy led in by the funeral director, page 2 should be detached for use as the bear in the funeral director, page 2 should be detached for use as the bear or the funeral director, page 2 should be detached for use as the bear or						24a. Was a		utopsy findings availab completion of cause of	
COF e law r e has b e 2 sh	Completed					perform	ned? death?		
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of \officers	-	27. Manner of Death	28a. Date of Injury (Month, Day, Year) FOUND:	28b. Time of Injury FOUND:	28c. Injury at Work?	Subject shot	ow injury occurred self		
sion ttendi death. ctor: y the f	Certification:	1 Natural 5 Pending 2 Accident Investig	Oct 14, 2007	1140 hrs	ctory, office building, etc.		treet and Number or R	ural Route Number, C	
Divis al or A s after al Dire	ijij	3 Suicide 6 Could r	not be		otory, emoc baneing, and	or Town St	ate) i Avenue , Middle Ri		
Lospita 4 houn 7 unera		4 Homicide 29a. Certifier 1 Certifying Physics Check only	-1-i To the heat of my knowl	ledge, death occurred	at the time, date and plac	e, and due to the cause	e(s) and manner as sta	ted.	
Division of Vital Rec To the Hospital or Attending Physician: The la within 24 hours after death. To the Funeral Director: After this certificate h completely filled in by the funeral director, page?	Medical	one) 2 Medical Exami	ner:On the basis of examination and manner stated.	n and/or investigation,	in my opinion, death occ	urred at the time, date a	and place, and due to the		
F » F S	≊	29b. Signature and title of certifier	1 - 0 - 0 - 4 - 0 =		29c. License number O.C.M.E.		29d. Date signed (Mo		
10		Jasha -	leefun	tom 22n\	J.O.IVI.L.				
10		30. Name and address of person water Tasha Greenberg MD.	ho complet of cause of death (II Assistant Medical Exa		nn Street, Baltimor	e, MD 21201			
S	tat€	31. Date filed (Month, Day, Year)	32. Registrar's Sign	nature					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hydiene

		1	For	Certificate of Death		1 No 2 1 1 7 3 3 2 9 L		
7	No. 14		Decedent's Name (First, Middle, Last)		Date of Death Month	Day Year		
	Physicia /Medic	- W	Edward R. Stumpf		October			
	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death		
	N. D. 1-45 - 10		Shady Grove Adventist Hospital	Rockville thday) If Under 1 Year If Under 24 Hrs.	8. Date of Birth	Montgomery		
	Funeral Director		5. Social Security Number 060-32-4750 6. Sex 1 ↑ Age (In yrs. last bir	Yrs. Months Days Hours Min.	(Month, Day,) November 1	(Year) 9. Birthplace (State or Foreign Country) 1. 1940 New York		
- 7	5		Usual Residence of Decedent	and position		10d. Inside City Limits		
-	show d at	Ž	Tod. Glate			1 □Yes 2 ☑ No		
4	28a-f	Director	Maryland Montgomery Rock 10e. Street and Number	ville 10f. Zip Code	10	g. Citizen of What Country?		
1	aor	흐		20852		United States		
4	is 23	era	10401 Grosvenor Place, #1221 11. Marital Status 12. Was Decedent Ever in U.S.	13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - American Indian,		
3	be filed within 72 hours after death with the maryland that Hygiene. ad other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by Funeral	Armed Forces? 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 5 Never	1 ☐ Yes 2 ☑ No Specify:	o Rican, etc.)	Black, White, etc. Specify: White		
	/2 noul	Completed b		Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired)	king	6b. Kind of Business/Industry United States		
7	al Hygiene. I other than " vent, the Mec	ldu	Elementary/Secondary (0-12) College (1-4or 5+) 5+	Diplomat		Department of State		
ч.	Hygie Hygie Ither I	ပ္ပိ	17. Father's Name (First, Middle, Last)		ne (First, Middle, M	laiden Surname)		
_	ental ked o	To Be	Edward Stumpf	Winifr	ed van Or	der		
	ges 1 and 2 should be it of Health and Menta If item 27 is marked or other traumatic ev	-	19a. Informant's Name/Relationship (Type. Print)	b. Mailing Address (Street and Number or Ru				
Š	1 and 2 Health a sem 27 Is)401 Grosvenor Place,				
=	es 1 a of He∉ fitem rothe		20a. Method of Disposition 2DRomoval from State	of Disposition (Name of ery, crematory or other place) Octo	ber 15,	20c. Location - City or Town, State		
Ξ,	Pages nent of ant: If its ary or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Montgon	ery Crematorium	2007 B	Bethesda, Maryland		
Dall	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Licensee M01473	Pumphrey Funeral Home/ lontgomery Avenue, 2805				
			23a. Part1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line.		or respiratory arre	est, Approximate Interval Between		
,	Physician		I I O /First	ctive Pulmonary Dise	ase	Onset and Death 2 Days		
•	/Medical		resulting in death) a. CITI OFFICE OBSET OF THE OBSET OF					
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Ö	w requir been si should I	Completed			24a. Was a	n 24b. Were autopsy findings available		
ě	has l	Ig II			autops perforr	med? death?		
<u></u>	iclan: Th certificate rector, pag		25. Was case referred to medical	26. Place of De	1 Yes 2 ath (Check only on			
5	sicla certi irecto	o Be	examiner?	Other:		ence 6 ☐Other (Specify)		
ō	Attending Physiclan: r death. ector: After this certifics by the funeral director, t	- T	27. Manner of Death 28a. Date of Injury 28b	. Time of 28c. Injury at hours	28d. Describe ho	ow injury occurred		
0	nding tth. r: Afte e fun	ig.	1 StNatural 5 Pending (World, Day Year) 2 ☐ Accident investigation	M 1 ☐ Yes 2 ☐ No				
Division or Vital Records,	or Atte	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of injury - At home, building, etc. (Specify)	farm, street, factory, office	28f. Location (St City or Town	treet and Number or Rural Route Number, n, State)		
_	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page		29a. Certifier (Check only (Ch	ge, death occurred at the time, date and plac and/or investigation, in my opinion, death occ	e, and due to the courred at the time, d	ause(s) and manner as stated. date and place, and due to the cause(s)		
	the H hin 24 the F mplete	Medical	one) and manner stated.	29c. License number		29d. Date signed (Month, Day, Year)		
	vit To	-	29b. Signal title of certifier	D0064502		ctober 12, 2007		
	15X1		30. Name and address of person who completed cause of death (Item 23a			CLUBCE 12, 2007		
	121		Brian Carpenter, M.D. 9901 Medica	al Center Drive, Rock	cville. M	ary1and 20850		
	St	tate	22 Registrar's Signature					
	Regist		OCT 1 7 2007	graves.				

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** John Elvin Schylaske October 12, 2007 5:13 AM^M /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore 2216 Vailthorne Road Middle River Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours July 13. 1924 206-12-9718 83 Pennsylvania Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 28a-f show 1 ☐ Yes 2 No "natural", or items 23a or 28a-f st edical Examiner must be notified Director Middle River Maryland Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number permit. Pages 1 and 2 should be filed within 72 hours after death with t Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 2 and 1 plury or other traumatic event, the Medical Examinar must be not 0.00. 2216 Vailthorne Road 21220 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1943-Baltimore, Maryland 21215-0036 1 ☐ Yes 🍇 No Specify: White Completed by 3 Widowed 4 ☐ Divorced 1945 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Mechanic Automobile 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Dorothy Magdalena Earhart John Henry Schylaske 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1557 Harford Square Drive, Edgewood, Maryland 21040 Joseph Henry Schylaske (Son) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition XXBurial 2 Cremation 3 Removal from State Greenwood Cemetery Tower City, Penn. 4 ☐ Donation 5 ☐ Other (Specify) 2007 22. Name and Address of Facility Bruzdzinski Funeral Home, P.A. 21. Signature of Juneral Service Lice 1407 Old Eastern Avenue, Essex, Maryland 21221 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) mesothelioma, **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or se a consequence of) Examiner The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) P.0. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. or Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably ♣️XUnknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a, Was an Fo the Hospital or Attending Physician: ours after death.

eral Director: After this certificatiled in by the funeral director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient Other: 4 Nursing Home XX Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 1 ☐ Yes 2XXNo Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. 28d. Describe how injury occurred 27. Manner of Death Injury at Work? Injury Division XX Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 | Homicide within 24 hours a XXCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier who completed cause of death (Item 23a) (Type, Print) 9110 Philadelphia Road Rosedgle Maryland 21237

Registrar

OCT 1 7 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Physician 4c. County of Death Loretta C. Sentz October /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner If Under 1 Year | If Under 24 Hrs 8. Date of Birth (Month, Day, Y ranklin Birthplace (State or Foreign Country) Social Security Number (In yrs. last birthday) 6. Sex **Funeral** ^{Year)}1937 Months Days West Virginia 1 □ M 2 🗗 F Hours 70 Director 212-36-5580 Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2√2 No Director Maryland Baltimore Middle River 10g. Citizen of What Country? 10e, Street and Numbe 10f. Zip Code "natural", or items 23a or 21220 U.S.A. 662 West Kingsway Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 □ Yes 21 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes **XX**No Specify: Specify: White Be Completed by 3X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed will Department of Health and Mental Hygien. Important: if item 27 is marked other the any injury or other trainmant. Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Stanley Warner Bessie Arbogast ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3930 Bayville Road, Baltimore, Maryland 21220 Kenneth Sentz, Jr. (Son) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Belair Memorial Gard. 10/17/2007 Bel Air, Maryland 21. Signature of Funeral Service Licensee ^{22. Name and Address of Facility} Bruzdzinski Funeral Home, P.A. 1407 Old Eastern Avenue, Essex, Maryland 21221 23a. Part I Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immuniate Cause (Final dinase or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Due to (or as a consequen Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last of) Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attandion an uniformal Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗙 No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 □ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autops, performed: 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 2 ☐ ER/Outpatient 3 ☐ DOA 1 🔲 Yes 1 Inpatient Medical Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Deat 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1 🗶 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar

1

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

7 2007

OCT 1

32. Registrar's Signature

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

29d. Date signed (Month, Dav. Year)

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 0 7

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				AMILTON			will	600	10 HAR	FOKD	(CAD	M	Dabla Imora	
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Darius Solers	

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State of Maryland / Department of Health and Mental Hygiene

arius Soiers		State of Maryland / Department of 1-For State Certificate of		ygierie Reg. N	200	7 3329
Physici	an/	Registrar 1. Decedent's Name (First, Middle,Last) Darius Sollers		2. Date of Death Month Da October 8, 20	3	3. Time of Death
ledical Exam	iner	4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	1200 1110
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Funeral Director		5. Social Security Number 212–98–9688 6. Sex 1 M 2 F 7. Age (In yrs. last birthday)	Months Days Hours Min		Foreign	
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Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important. If It item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	Completed		ent's Ūsual Occupation (Give kind of most of working life, DO NOT use rel		b. Kind of Business/In	unk
215-0036 be filed within 7 mtal Hygiene. rked other than ent, th. Medica	Com	17. Father's Name (First, Middle, Last) Charles Sollers	18.Mother's Nam	e (First, Middle, Maid Brenda	len Surname) Bright	
2121 2121 Judy be fi Mental marked	To Be	19a. Informant's Name/Relationship (Type, Print) 19b. Maili	ng Address (Street and Number or	Rural Route Number	, City or Town, State,	Zip Code)
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Baltimore, permit. Pages 1 ar Department of Hes Important: If ite		1 X Burial 2 Cremation 3 Removal from State crematory or C	other place)		Baltimore, M	
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Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	edical C	29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigant manner stated.	curred at the time, date and place, argation, in my opinion, death occurred	nd due to the cause(s d at the time, date and	s) and manner as state d place, and due to the	ed. e cause(s)
5 × 50 00	Me	29b. Signature and title of certifier	29c. License number		9d. Date signed (Mor	nth, Day, Year)
		Source IN Inventi, n.D. 30. Name and address of person who completed cause of death (Item 23a)	O.C.M.E.		October 9, 2007	
17		Donna M. Vincenti, MD Assistant Medical Examiner 1	11 Penn Street, Baltimore,	MD 21201		
Regi	State	110 - 1 1 / /) M 1 / / / / / / / / / / / / / / / / / /	foods			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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	Medic xamin	al	4a. Facility Name (If not institution, give street and number) 4b. City, Town,	or Location of Death	lo	4c. County of Deat	
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	neral ector		5. Social Security Number 214-54-6721 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year Months Days		8. Date of Birth (Month, Day, Ye Nov. 4, 194	e <i>ar) C</i> o	hplace (State or Foreign untry) MD
yland	at d		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			•	10d. Inside City Limits
ne Mar	odilis	ector		imore	140	O'S'	1 X Yes 2 ☐ No
with th	t be n	Dir	10e. Street and Number 10f. Zip Code 3412 Mayfair Road	21207	10g.	Citizen of What Co	untry ?
after death	niner mus	Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Never Married 2 ☐ Married 1 ☐ Never Married 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No	Hispanic Origin? (Sp ban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame	
hours a	I Exan	d by	3 ☐ Widowed 4 ☐ Divorced Year or Dates:		161	b. Kind of Business/	
hin 72	item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medikal Examiner must be notified at	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	e during most of work		o. Kind of Business/	mousty
led with		Сош	12 driver		e (First, Middle, Mai	catering con	npany
d be fill ental H	c ever	To Be	17. Father's Name (First, Middle, Last) Linwood Fowlkes	To. Mother's Name	e (riisi, wilddie, wal Marian (,	
ary shoul and M	umati	F	19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street				Zip Code)
and 2	her tra		Sylvia Lyles / Sister 3311 Sequoia .	Land 21215 c. Location - City or	Town State		
permit. Pages 1 and 2 Department of Health a	ury or ot		20a. Method of Disposition 1元 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other pl	ings Mills,			
permit Depart	any In			ress of Facility Wy lmor Street;		•	21217
Ş.,			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dy shock, or heart failure. List only one cause on each line.	ring, such as cardiac	or respiratory arrest	,	Approximate Interval Between Onset and Death
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Exan							
	sit	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury				
oor ou, flicate be executed	pnysician and the burial-transit	Examine	that initiated events c				
ficate be ex	nysicia the bur	edical	d				
certifica dina	se as t		IF FEMALE: 23c. If yes, outcome pf pregnancy		23d. Date of de	livery	
the death ce	y me aner ched for u	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnant at time of death 5 ☐ Other (specify).		Month	Day Year	
S, F	gned by	by Pr	Part II. Other significant conditions contributing to death but not resulting in the underlying cause g		o the cause of death?		
records,	hould t					2 No 3 P	
The law	page 2 s	Completed			24a. Was an autopsy performe	prior to death?	utopsy findings available completion of cause of s 2 □ No
VICAL Sician: T	rector,	Be	25. Was case referred to medical examiner? 1 Yes 2 No		th (Check only one)	a □0+ (0	
g Phy	ier mis ieral di	n: To	27. Manger of Death 28a. Date of Injury 28b. Time of 28c. Injury	4 🗆 Nursing 🗆	28d. Describe how		еспу)
VISION r Attending er death.	the fur	catio	2 Accident investigation M 1	□Yes 2□No			
al or Attending F s after death.	d in by	Certification:	3 Suicide 4 Homicide 4 Homicide 4 See Place of injury - At home, farm, street, factory, office building, etc. (Specify)	e	28f. Location (Stree City or Town, 3	et and Number or R State)	ural Route Number,
To the Hospital or Attending Physician: The law requires that the death certify within 24 hours after death.	e runeral etely filled	edical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the 2 Medical Examiner: On the basis of examination and/or investigation, in my and manner stated.				
To the within	compl	Me	29b. Signature and title of certifier 29c. Lices	. Date signed (Mon			
•	1		V,	10/16/03	? 		
1	YI		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) University of Maryland 22 3. Grent street Baltman	15 QM, s	20 i		
F	Sta Registr		University of Maryland 22 5, Greene street, Baltona. 31. Date filed (Month, Day, Year) OCT 1 7 2007 Registrar's Signature				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
AMEND TIPM// perFH 08/2, 10/17/07 WS
State of Maryland / Department of Health and Mental Hygiene 0 7 For State Registrar 1-Certificate of Death 1) Decedent's Name (First, Middle, Last) (2) Date of Death 3. Time of Death **Physician** 10/21 Momisson -200 48 DM 10 0 /Medical (4a) Facility Name (If not institution, give street and number) (4b) City, Town, or Location of Death 4c.)County of Death Examiner Count GENESIS Health Randallstown Care | If Under 1 Year | If Under 24 Hrs. | 8 Date of Birth (Month, Day, Year) | 1 25 2 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🖾 F Yrs. Director 212-42-6316 Usual Residence of Decedent VA the Maryland 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits rai', or items 23s or 28e-f ehow Examiner must be notified at X□Yes 2□No Director Baltimore MD NA 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code with permit. Peges 1 end 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene important: if Item 27 is marked other than "natural", or Items 23a eny injury or other traumatic event, the Madical Examples market once. 21216 U.S.A. 4021 Bateman Ave Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes Y ☐ No Specify: δ Specify: Black 3 Widowed 4 □ Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16h. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker House 8th grade na 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Georgia Dawson Jimmy Plunkett 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 531 Church Road, Reisterstown, Md 21136 Paris Evans=Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State M□ Burial 2 □ Cremation 3 □ Removal from State ☐Donation 5 ☐Other (Specify) 10/17/07 Pikesville, Md Druid Ridge ature of Funeral Service Licensee, 22. Name and Address of Facility
March F/H West
4300 Wabash Ave, Baltimore, Md 21. Sig 21215 VG art1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician oronary /Medical Due to (or as a consequence of): Examiner Stage Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) physicien s the burial Physician/Medical as attending for use as IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy Month Dav Year 4☐Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 ☐NO 3 Probably 4 ☐Unknown been si 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? s certificete has the firector, page 2 s autopsy performed? 2 0 No 1 ☐ Yes 2 ☐ No 1 Yes Attending Physician: director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: Sursing Home 5 Residence 6 Other (Specify) ဥ 1 ☐ Yes 2 ☐ Mo this After this 27. Manner de ath 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation death. 1 ☐ Yes 2 ☐ No ector: A 2 Accident 3 ☐ Suicide 6 ☐ Could not be Direct 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours effer of To the Funerel Direct completely filled in by determined 4 Homicide ö To the Hospitai 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicaf Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical

Registrar

State

2

DHMH 17 Rev 1/2001

29b.

Signature and title of certified

31 Date filed (Month, Day, Year)

1060

2007

Baltimore, Maryland 21215-0036

P.O. Box 68760,

Division of Vital Records.

29c. License number

29d. Date signed (Month, Day, Year)

and manner state

Say

1850

32. Registrar's Signature

		4	For State	State of Maryland						07	333	R N I
		_	Registrar		Cer	tificate of D	reau i	2. Date of Deat	g. No← U	0,	3. Time of	
	Physicia		Decedent's Name (First, Middle, Last) T	T 1 m 1	4 4			Month October	Day	Year	9:40	A M
	/Medic	al L	James		ieri	4b. City, Town, or I	Languing of Dogst		_	y of Death	7.40	
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			Shady Grove Advent	7. Age (In yrs. I	lact hirthday)	Rockv		8. Date of Birth		gomer	y place (State o	r Foreian
	Funeral	1		M 2□F 82	Yrs.	Months Days	Hours Min.		Year) 1915	Cour	Jersey	
	Director	-	Usuel Residence of Decedent	02				Jenically 2	, 1715	1.00	30150)	
	and		10a. State 10b. County	10c. City	, Town or Lo	cation				1	0d. Inside Ci	
	f eh	ō	Maryland Montgom	nery	Silver	Spring					1 🗌 Yes	2 X No
	158 286	Directo	10e. Street and Number			10f. Zip Code		1	0g. Citizen of	What Cour	ntry?	
	3a or		3310 N. Leisure Wo	rld Blvd., #8	306	20906		1	United	Stat	es	
	19eth	Funeral		2. Was Decedent Ever in U.		Was Decedent of His f Yes, specify Cubar	spanic Origin? (S	Specify Yes or No-		ce - Americ		
Ω	ifter of the second	F	1 ☐ Never Married 2 ☐ Married	Amed Forces?		Tes, specify Cubar		to riloan, otc.,	Spec		nite	
3	within 72 hours after deeth with the Maryland ene. than "natural", or iteme 23a or 28e-f ehow tha Madical Examinari, wat be notified at	ð	3 Widowed 4 Divorced	If Yes, Give WW Year or Dates:	ATT	10103 20110						
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Maryland	be filed within 72 ho ital Hygiene. id other than "natur event, the Modical	Be	17. Father's Name (First, Middle, Last)									,
<u>Ş</u>		ဥ	Salvatore Taglieri		405 14-10	ng Address (Street a		Lucille N			Code)	
<u>a</u>	2 sh and 1s m		19a. Informant's Name/Relationship (Typ			_						Í
	s 1 and 2 should f Health and Men item 27 is marke other traumatic	١.	Gloria M. Taglieri			. Leisure W		Date	20c. Location			
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E	meniment:		4 □ Donation 5 □ Other (Specify)			Crematorium,	,	_	Bethesda			
Bai	permit. Page Department Important: financiant: fant injury o		21. Signature of Funeral Service License	-	RC	Name and Addres bert A. Pun	phrey Fun	eral Home/1	Rockvill	e, Inc	. 20050	0005
	0.0 <u>₽</u> • 0		May itel	M0130		0 West Mont				aryland		
п		23a. Part 1 Atterthe disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or resshoot or heart failure. List only one cause on each line.									Approxima Interval Be Onset and	ween Death
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	/Medical Examiner		resulting in death)	Due to (or as a conseq		U	, ,	}				7
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Box	ath c	ian	in the past 12 months?	1 Live birth 2 ☐ Feta 4 ☐ Pregnant at time of o	at death 3	☐Ectopic pregnancy ☐ Other (specify)				Month	Day	Year
o.	the de	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown		_ ce. (cpccy)						
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Vital Records,	sign d be	1 by	Preomo	nie				1 🗆 Y	′es 2 ∐°No	3 ☐ Pro	bably 45	Unknown
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3ec	hes l	Completed						autop	rmed?	prior to o death?	ompletion of	cause of
a E	ician: The L certificete he ector, pege						00 Di 1 D-		2 No	1 ∐ Yes	2 🗆 No	
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Division of	efter Oirs in b	Certification:	4 Homicide determined	building, etc. (Speci	ity)			City or Tox	vn, State)			
_	To the Hospital or Attend within 24 hours effer death To the Eunerel Director: completely filled in by the		29a. Certifier 1 Certifying Phys	sician: To the best of my kn	owledge, dea	th occurred at the tir	ne, date and plac	ce, and due to the	cause(s) and	manner as	stated.	/-\
	• Ho: 24 h • Fur	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
	To the within 2 To the comple	Me	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)									
	->	1	1 America	Donal	NE	ID DZ	8262	_	Ode	10	200	7
	, D	1	30. Name and address of person who co	ompleted cause of death (Ite	m 23a) (Type	, Print)		LVD S		1	MO	10850 Mlo
	10	}	DA MENDY		2401	15-68-60	av ch B	LVD S	ute:	3301	ROCK	rllo
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DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 2007

		•	1 - State Registrar			Cer	rtificate of	Death		Reg. No.					
\$			1. Decedent's Name (First, Middle		Mo						2. Date of Death 3. Time of I				
	Physicia /Medic			Raj Rani	Verma	a 			Octobe	r 14,	2007	12:10	P^{M}		
1	Examin		4a. Facility Name (If not institution	, give street and number)				r Location of Dea	th	4c. 0	County of Death				
	<u> </u>		Shady Grove Adv				Rockvi		0 D-4(B)		Montgom		E		
н	Funeral		5. Social Security Number None	6. Sex 7. Age 1 M 2 ★ F 8.	(In yrs. las	st birthday) Yrs.	Months Days	Hours Mir	. (Month, D.	ay, Year)	Cou	place (State or ntry)	Foreign		
i.	Director		Usual Residence of Decedent	0.	5	110.			July 2	5, 192	$22 \mid \text{Inc}$	lia			
	and w		10a. State 10b. County		10c. City,	Town or Lo	cation					10d. Inside City	Limits		
	Mary f sho	o	Maryland Mant	gomerv		Boyd	S					1 XYes	2 □ No		
	the 28a-	Director	Maryland Mont	30mer y			10f. Zip Code	<u></u>		10g. Citiz	en of What Cou	ntry?			
	3a or		18407 Polynesia	an Lane			20	0841		Tr	ndia				
	ms 2	Funeral	11. Marital Status	12. Was Decedent E	ver in U.S.	. 13. \	Was Decedent of H		Specify Yes or N		Race - Amer				
9	after or Ite nine		1 ☐ Never Married 2 ☐ Marr	Armed Forces? ied 1 ☐ Yes 2 📉 N If Yes, Give	lo		1 □ Yes 2 🛣 No	Specify:	ito riican, etc.)		Black, White				
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21215-0036	filed within 72 hours after death with the Maryland Hygiene. wither than "natural", or Items 23a or 28a-f show ent, the Medical Examiner must be notified at	Completed	15. Deceden (Specify only higher			16a. Deced (Give	dent's Usual Occu kind of work done DO NOT use retire	pation during most of w	orking	16b. Kin	nd of Business/li	ndustry			
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	led w lygier her tl nt, th		8	t oot)		пс	memaker	18 Mother's N	ame (First, Middle		Own Hom	<u>e</u>			
pu	be fil stal H d otl	Be	17. Father's Name (First, Middle, Bhagwan Sing						ane (rusi, whole a Rani	s, maideri c	Surname)				
χ	should be f and Mental I s marked of umatic eve	ဥ		·		10b Mailir	ng Address (Street	L		har City ar	Town State 7	in Cade)			
Maryland	12 st h and 7 Is n traun		19a, Informant's Name/Relations				•								
	1 and Health em 27 ther tr		Rajendra K. Ver	ma/son	20b. Pla	ce of Dispo	Polynes	i	Date	20c. Loc	YIANG Z cation - City or 1	OO41 own, State			
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		1 Burial 2 XCremation		Mon	t como	matory or otner pla	Oct	ober 15,	 Reth	nesda, N	farvl and	1		
Ħ	it. P.		4 ☐ Donation 5 ☐ Other (S		Cre	mator	iim, Tnc.	ess of Facility	2007	Deti	Rethe	sda-Che			
Ba	permit. Departr Importa any inji		1 RAY	1	100198	Re	ium, Inc. Name and Addr obert A. 557 Wisco	Pumphre	y Funera	1 Hom	ne/Chase	Inc.	- • •		
	_		23a. Part1. Enter the disease, or		OULIC		THE WISCO	HSTH AVE		مفلاد	MD ZUOT	Approximate			
	Dharalalan		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final										eath		
	Physician /Medical		disease or condition resulting in death)	a. Pulno Due to (or as a			tension					Unknow	n		
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	eath certificate be executed attending physician and for use as the burial-transit	Medical Examiner	Cause (Disease or injury that initiated events	С.											
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Bo			23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 ☐Live birth	2 Fetal	death 3	⊒Ectopic pregnand	у		2	23d. Date of deli Month		'ear		
	e des the at ned fo	sici	1 ☐ Yes 2 🔯 No 9 ☐ Unknown	4□Pregnant at 9□Unknown	time of dea	ath 5	Other (specify)_					,			
P.0	requires that the death cer een signed by the attendir nould be detached for use	Physician	Part II. Other significant condition	ons contributing to death bu	it not result	ting in the u	nderlying cause gi	ven in Part I.	23e. Did	tobacco u	se contribute to	the cause of de	eath?		
S,	ires ti signe	by	Tarri. Other signmount contain	2112 Continuating to document			,, ac.,, ., .,				□No 3□Pro				
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ō	Phys r this ral di	은 -:	1 ☐ Yes 2 ☐ No 27. Manner of Death	1 X Inpatie		28b. Time o	IL 3 DOX	4 🗆 Nursing	Home 5 ☐ Res			erry)			
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isi	Atten deatl ctor: y the	fical	3 Suicide 6 Could	not be 28e. Place of inju	ıry - At hon	ne, farm, st	reet, factory, office		28f. Location	(Street and	d Number or Ru	ral Route Num	ber,		
Ξ	lor / after Dire	ertii	4 ☐ Homicide determ	building, etc	c. (Specify))			City or To	own, State,)				
	To the Hospital or Attending Physician; The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.	Medical Certification:		ng Physician: To the best o									`		
	te Ho 7 24 h re Fu	dic	(Check only 2 Medical one)	Examiner: On the basis of and manner sta		on and/or ir	nvestigation, in my	opinion, death of	curred at the time	e, date and	place, and due	to the cause(s)		
	To the I within 2 To the complet	Me	29b. Signature and title of confine	7				se number			te signed (Monti		7		
			Musical	un	D.O.			66189		O	ctober :	14, 200	/		
	5		30. Name and address of person												
_	ン		Andrew Meenaks				Center	Drive, R	ockville	, Mai	ryland 2	20850			
	Sta		31. Date filed (Month, Day, Year)	. Registra	ar's Signati	ure	. AP .								
	Regist	rar	OCT 1 7	2007 Keren	, St.	April	ME!								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death SALLY ANN VAN KIRK October 15, Physician /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 1635 Pleasantville Drive Glen Burnie Anne Arundel If Under 1 Year | If Under 24 Hrs. Social Security Number 227-20-3138 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral Months Days 1 □ M 2 🔀 F Hours Min. 82 Director Jan 27, 1925 Virginia Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location r 28a-f show notified at 1 □Yes 2 No Glen Burnie Maryland Anne Arundel Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or any hiury or other traumatic event, the Medical Examiner must be 1 and 10ne. 1635 Pleasantville Drive 21061 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 전 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0036 1 ☐ Yes 2 🛮 No Specify: White Specify. Be Completed by 3 Midowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker & Mother Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Roland Northam Margie B. Matthews ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Frederick Raymond Van Kirk, Jr. 8051 High Oak Road, Glen Burnie, Md. 21060 20b. Place of Disposition (Name of cemetery, crematory or other place) Loudon Park Cemetery 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 10/18/07 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Name and Address of Facility Runeral Home, P.A. 237 E. Patapsco Ave., Balto., Md. 21. Signature of Funeral Service Licensee Kevin E Ecker 21225-1856 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed the burial-trai Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 No Month 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a 9□Unknown 9 Unknow cate has been signed page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe certificate Hospital or Attending Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 5 ☐ Pending investigation 1 Natural 2 Accident Injury To the magnetic within 24 hours after death. To the Funeral Director: After the Funeral Director of the further than the fur 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one)

Cl State Registrar

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

900 32 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CATON AVE BALTIMORE MD 21229

D16354

29d. Date signed (Month, Day, Year)

the

7-07982		Please Type	or Print in Black In	delible Ink.	Ensure	All Copie	s Are Legi	ible.	
Reginald Wilbur		State	of Maryland / Depa	rtment of He	alth and				3330
		1- For State Registrar		tificate of De	ath			. No.	
Physicia Medical Exami		1. Decedent's Name (First, Middle,Later) Reginal	Wilburi	n-El			2. Date of Death Month C October 12,		3. Time of Death 2145 hrs
		4a. Facility Name (if not institution, given University Hospital	ve street and number)		ltimore	Location of Death		4c. County of Death	
Funeral Director		5. Social Security Number 6. S 213-88-2093 12	ex 7. Age (In yrs. la		Inder 1 Year onths Days			Foreig	thplace (State or in untry)
5-0036 ret within 72 hours after death with the Maryland bygiene. other than "natural", or items 23a or 28a-f show any the Medical Examiner must be notified at once.	eral Director	Usual Residence of Decedent 10a. State 10b. County 10e. Street and Number 2800 Residence of Decedent 11. Marital Status	erstown 12. Was Decement Ever in U.	R 44 S. 13. Was Dec		2/5 panic Origin? (Sp., Mexican, Puerto	ecify Yes or No-	3. Citizen of What Cour	10d. Inside City Limits 1 Yes 2 No ntry?
	/ Funeral	Never Married 2 Married Widowed 4 Divorce	1 Yes 2 No	1 Yes	rtm.	specify:	Nicali, etc./	Specify: R	lack
iours af	ed by	15. Decedent's Education (Specify of	or Dates:	16a. Decedent's Us	ual Occupat			16b. Kind of Business/	Industry
5-0036 led within 72 hours afte Hygiene. other than "natural", the Medical Examiner	Completed	Elementary/Secondary (0-12)	College (1-4 or 5+)	Dis	abl	ed	, ou,	N/	4
	Be Co	17. Father's Name (First, Middle, Last	Milburg	^		18.Mother's Name	(First, Middle, Ma	aiden Surname)	,
21214 hould be fill nd Mental F is marked tric event, I	ם	19a. Informant's Name/Relationship (Type, Print) (mother	19b. Mailing Add	ess (Stree	t and Number or F	Rural Route Numb	per, City or Town, State	e, Zip Code)
MC saum		Wrs, Josephii 20a. Method of Disposition	ne Herrine	lace of Disposition (Name of cer	netery,	NOOD,	ST Bulto 20c. Location - City or	Ma, 2/2/6 Town, State
Baltimore, permit. Pages 1 a Department of He Important: If it		1 Burial 2 Cremation 3 4 Donation 5 Other Specify	Temoval nom State	hutus A	lem. K	ark 101	19/2007	Balto.	Md
Baltim permit. Pag Department Important: injury or or		21. Signature of Funeral Service Lice		22. Name To Se	and Address	of Eacility	Funer	af Home	P.H
Physician		23a. Part I. Enter the disease, or com		Do not enter the mo	de of dying,	such as cardiac o	r respiratory arres	st, shock, or heart	Approximate Interval Between Onset and
/Medical xaminer		failure. List only one cause on e Immediate Cause (Final disease a or condition resulting in death)	Multiple Injuries						Death
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	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated	Due to (or as a consequence of	f):					
ecuted and transit		events resulting in death) Last	Due to (or as a consequence of	f):		-			
ĕ = I	dical	UNPENDED	AMENDED		·	-			
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be exwithin 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician completely filled in by the funeral director, page 2 should be detached for use as the burial.	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknow	23c. If yes, outcome of preging the Live birth 4 Pregnant at time of de	2 Fetal de		Ectopic pregna	ancy	23d. Date of deliver Month	y Day Year
P.O. E es that the cigned by the conference of t	by Ph	Part II. Other significant conditions		esulting in the underl	ying cause o	given in Part I.		pacco use contribute to	the cause of death?
Division of Vital Records, Find or Attending Physician: The law requires are after death. al Director: After this certificate has been signed in by the funeral director, page 2 should be	Completed						24a. Was ar autops perforn	n 24b. Were at y prior to ned? death?	utopsy findings available completion of cause of
Re I: The tiffcate		25. Was case referred to medical			26 Place	of Death (Check	1 Yes 2	No 1 ✓ Y	es 2 No
Vita ysician his cer directe	o Be		Hospital: 1 Inpatient 2	ER/Outpatient 3	DOA	Other:		Residence 6 Othe	er:
on of Parting Phart. After the funeral	-	27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury Oct 12, 2007	28b. Time of Injury 0130 hrs		ry at Work? Yes 2 ✔ No	28d. Describe ho Pedestrian st	ow injury occurred truck by auto	
Division and the control of the cont	Certification:	2 Accident Investigar 3 Suicide 6 Could no determine	t be 28e. Place of Injury - At ho		tory, office t	ouilding, etc.		treet and Number or Ri ate) 'Smallwood Street	ural Route Number, City
the Hosp thin 24 ho the Fune	Medical C	29a. Certifier (Check only 1 Certifying Physic	cian: To the best of my knowledger: On the basis of examination a	-					
To To Sin	Me	29b. Signature and title of certifier	and manner stated.		29c. Licens			29d. Date signed (Mo	
		20 Name and address of	completed course of death //-	232)	O.C.	IVI.E.		October 14, 200	1
3		 Name and address of person who Ana Rubio MD. Assista 		111 Penn Stree	t, Baltimo	ore, MD 2120	1		
St Regis		31. Date filed (Month, Day, Year) OCT 1 7 2	32. Registrar's Signatu	re Land	R				

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2007 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician Woodlon Pemberton Gladys Elizabeth 2007 7:55a. M 10 13 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Elesy Manor Assisted Living if Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday **Funeral** 1 M X F Months Days Hours 220-01-6371 22 91 MD Director 02 16 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits la or 28a-f show t be notified at 10b. County Baltimore 1X Yes 2 □ No NA Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with ment of Health and Mental Hygiene.
ant: If Item 27 is marked other than "natural", or items 23a or any or other traumatic event, the Medical Examiner must be n 21215 U.S.A. 3613 Seguoia Ave Funeral Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specity Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√☐ No þ Specify: Black 3 ☐ Widowed 4 ☑ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 12th grade College (1-4or 5+) Federal Gov't File Clerk 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pearl King Robert Gray Pemberton o L 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3613 Sequoia Ave, Baltimore, Md 21215 Roberta Scott-Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 'Department of H Important: If Ite any injury or of 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc 10/16/07 Baltimore, Md 21. Signature of Funeral Service Licensee March F/H West 21215 4300 Wabash Ave, Baltimore, Md Approximate Interval Between Onset and Death 23a. Parti. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart dilure. List only one cause on each line. Immediate Cause (Final MRTERIOSC **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examine To the Hospital or Attending Physiclan: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760-6 attending physician and for use as the burial-trai Due to (or as a consequence of): Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 ☐ Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 ☐ Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ 40 24a. Was an page 2 s autopsy performed? 1∐ Yes 2 🛣 No Be 25. Was case referred to medical 26. Place of Death (Check only one) ASSISTE Other: 4 Nursing Home 5 Residence 6 Desuper (Specify) 25 No 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA P 7415 within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral director. 28d. Describe how injury occurred 28a. Date of Injury 28b. Time of 28c. Injury at Work? 27. Manner of Death Certification: (Month, Day Year) 1 Natural 2 Accident Injury 5 ☐ Pending 1 □ Yes 2 □ No investigation 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month. Day, Year) 29b. Signature and title of certifier 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print 32 Registrar Signature 31. Date filed (Month, Day, Year) State park OCT 1 2007 Registrar

Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** 2007 7:36P OCTOBER 12, ETTA C. WILLIAMS /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner LaPLATA CENTER LaPLATA CHARLES If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Hours 1 M 3/5/F Yrs. 209 26 8824 APR. 01, 1925 NORTH CAROLINA 82 Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10c. City. Town or Location 10a, State 10b. County works r than "natural", or items 23a or 28a-f shov the Medical Examiner must be notified at XX Yes 2 No Director PRINCE GEORGES UPPER MARLBORO MD 10g. Citizen of What Country? 10e. Street and Number UNITED STATES 20772 5605 S. MARWOOD BOULEVARD Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black, White, etc. 1 and 2 should be filed within 72 hours after theath and Mental Hyglene. em 27 is marked other than "natural", or iten ther traumatic event, the Medical Examiner. 1 ☐ Yes XX No 1 Never Married 2 Married 1 ☐ Yes 🏋 🎗 No Specify: BLACK Specify: þ 3 ☐ Widowed 4XX ivorced ear or Dates: Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) ANNE ARUNDEL COUNTY College (1-4or 5+) Elementary/Secondary (0-12) PUBLIC SCHOOLS TEACHER / EDUCATOR 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) æ BERTHA BRYAN AGUSTUS GEORGE CHESTON ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) WALDORF, MD 20603 10629 SHOOTING STAR LN. JOHNNIE CHESTON / BROTHER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 ment of F Department of Important; If it any injury or o XIX Buriat 2 Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) FORT LINCOLN CEMETERY 10/20/07 BRENTWOOD, MD 21. Signature of Funeral Service Licensee 2 Name and Address of Facility MARSHALL'S FUNERAL HOME OF MARYLAND, IN 4308 SUITLAND ROAD SUITLAND, MD 20746 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shortk, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** SEPSIS /Medical Due to (or as a consequence of): **Examiner** PNEUMONIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed AIDS (AQUIRED IMMUNODEFICIENCY DISEASE) Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes XX No 4☐Pregnant at time of death 5 Other (specify) the 9 Unknown 9 Unknow by 23e. Did tohacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably XX Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an certificate has autopsy performed? 1∐ Yes XX No Hospital or Attending Physician: 25. Was case referred to medical examiner?____ 26. Place of Death Check onl one Be Hospital: 1 ☐ Inpatient Other: XX Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes XX No 2 ER/Outpatient 3 DOA Certification: To After this 28d. Describe how injury occurred 28b. Time of 27. Manner of Death 28a Date of Injury 28c. Injury at Work? (Month, Day Year) XX Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No M 2 Accident after death Director: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide within 24 hours a To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D61652 OCTOBER 16, 2007 10 30. Name and address of persen who completed cause of death (Item 23a) (Type, Print) 11350 PEMBROOKE SQUARE #304 WALDORF, MD 20602 ATUL KATYAL, M.D. 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Renee Dorsey 2007 33307 1- For State Certificate of Death Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day October 11, 2007 0800 hrs Medical Examiner Rence-White-Dorsey Renee Dorsey 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) **Baltimore** 2025 Ramblewood Road N/A 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year If Under 24Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Davs Hours Director 214-62-9371 M 2 X F Country) 1955 N/A 52 Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a. State 10h County N/A MD Baltimore 1 X Yes 2 No 23a or 28a-f show notified at once Director 10f, Zip Code 10g. Citizen of What Country? 10e. Street and Number 2025 Ramblewood Road 21239 USA Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? Never Married 2 X Married Yes Pages I and 2 should be filed within 72 hours after If Yes, Give Year 3 Widowed Divorced Yes 2x No specify: Specify: Black <u>م</u> 16a. Decedent's Usual Occupation (Give kind of work done 16b, Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) is marked other than ' 21215-0036 N/A Disabled 3vrs 12th of Health and Mental Hygiene. 18, Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be White Bernice Smith Charles ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore, MD t: If item 27 is other traumat 26th Baltimore, 320 E. <u>Bernice White-mother</u> 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 10/19/200 MD Randallstown King Memorial Pk. Donation 5 Other Specify: 22. Name and Address of Facility 21. Signature of Funeral Service Licensee MARCH FUNERAL HOME-EAST 21202 1101 E. North Avenue Baltimore, MD ans 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and failure. List only one cause on each line /Mudical Death Narcotic intoxication Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause Examine Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and Physician/Medical X AMENDED #1,23a,PII,27,28a-f. perME,0873, X UNPENDED attending physician or use as the burial 11/14/07 TT Box 68760 23d. Date of delivery IF FEMALE 23b. Was decedent pregnant in the Ectopic pregnancy Month Day Year Live birth Fetal death Pregnant at time of death 5 1 Yes 2 No 9 V Unknown jo Unknown signed by the a 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Ó ð 1 Yes 2 No 3 Probably 4 V Unknown Division of Vital Records, P. Cirrhosis Completed 24b. Were autopsy findings available certificate has been ector, page 2 should 24a. Was an prior to completion of cause of autopsy performed? death? Yes 2 No 2 No 1 🗸 Yes 26 Place of Death (Check only one) 25. Was case referred to medical Be examiner? Other 1 Residence 6 🗸 Other: Scene DOA Nursing Home 5 Inpatient 2 ER/Outpatient 3 this 1 Yes ٩ No 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury After 27. Manner of Death Certification: Natural Yes 2 X No Director: Pending within 24 hours after death.

To the Funeral Director: Fnd 10/11/2007 Fnd 7:30 am 2 Accident Investigation filled in by 28f, Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State) 2025 Ramblewood Rd. Baltimore, MD 3 6 X Could not be Suicide determined 4 Homicide found at home Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie O.C.M.E. October 12, 2007 OKACIN 30. Name and address of person w o completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Deputy Chief Medical Examiner Jack Titus MD. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001 **OCME 2006**

Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** ashinaton SR CTOBER 6 2007 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner 3810 Ednor Date of Birth (Month, Day, Year) 9-22-19 Birthplace (State or Foreign Country) 7, Age (In vrs. last birthday) Months 1**X**M 2□ F 217-22-661 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 Tres 2 No MD Completed by Funeral Director 1 timore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 12. Was Decedent Ever in U.S. Armed Forces? 12 Yes 2 □ No 17 Yes, Give Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 💥 No Specify: 3 Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be laylor 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 20b. Place of Disposition (Name of cemetery, crematory or other place) Pravie 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify) 3 Removal from State Trappe, MD 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) RECTUM THE CANCER Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examines Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ ANEMIA 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed CORONARY HEART DIJEAJE 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☑ No 24a. Was an autopsy performed? Yes 2 No 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Hospital: P 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 1 Natural 5 Pending investigation 1 □ Yes 2 □ No 2 Accident

Baltimore, be executed Box 68760, P.0. Records, Division or Vital death. To the Hospital of within 24 hours af To the Funeral D

Pages 1

Funeral

Director

r 28a-f show notified at

Department of Health and Mental Hygiene. Impure after recent with Important: If item 27 is marked other than "natural", or items 23a or amy injury or other traumatic event, the Medical Examiner must be none. **Physician** /Medical **Examiner** burial-trar physician the as. the attending nse s ρ signed by the a Id be detached for certificate has page funeral director, After this Certification: spital or Attendi nours after death. neral Director: A / filled in by the fu 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Descritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier DO061789 OCTOBER, 10, 2007 Hurch, MD

State Registrar

31. Date filed (Month, Day, Year)

LOPRAINE

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

OFORI ANUATIMO. 9106 PHILADELPHIA RD. STE 208, BALTIMORE, NO 21237

OCTOBER

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** ASHINGTON OLANDA ctober 15,2007 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltmore - Duloney A Maris Valle TIMONIUM Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Year) Months Hours Days 1 M 2 XF 217-92-5155 Director Maryland Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County "natural", or items 23a or 28a-f show sdical Examiner must be notified at 1 Ves 2 No Md. Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 12 Ü Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 2 No ac Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry or other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) marie's and Mental Hygiene.

Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Black # 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Baltimore, Division or Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No 2 0 0 7 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death WHISTLER **Physician** 0142 M 02 2007 /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Anne Arundel Hospice of the Chesapeake Harwood If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 DE Months Director 94 Oct 25, 1912 Michigan 380-01-9419 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits show "natural", or items 23a or 28a-f shovedical Examiner must be notified at 1 ☐ Yes 2√☐ No Director Annapolis Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21401 515 Majestic Prince Drive s 1 and 2 should be filed within 72 hours after death of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23s Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 _ } 1 ☐ Yes 2 📉 No Specify: Specify: whte 3 Vidowed 4 □ Divorced Year or Dates Completed other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry unk (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 office work 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ျှ Ernest Elbert Triplett Isabell Balmer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 114 Little Magothy View Annapolis, MD Carol Kerr/daughter permit. Pages 1 a
Department of He
Important: If Item
any injury or othe 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from Btate 4 ☑ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Rone Id S. Wade, 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician ears /Medical or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner certificate be executed as the burial-transit and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE: nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? ģ Month Day Year 4□Pregnant at time of death 5 Other (specify) the detached 9 Unknown 9 Unknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has autopsy perform certificate 1□ Yes Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence Of Other (Specify) Hospital: 1 ☐ Yes 2 No ဥ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death

1 Natural
2 Accident 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? After 5 Pending investigation 1 ☐ Yes 2 ☐ No death. To the Funeral Director: completely filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) To the Hospital or At within 24 hours after d To the Funeral Direct determined 4 ☐ Homicide 110 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number

State Registrar DEFENSE HIGHWAY ANNAPOLIS MOZITUI

leted cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene.

		•	For State Registrar	State of Ma	iryiaiiu / L		ificate of l			Reg. No.	/ 4 5 5 2 4	333		
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	min		4a. Facility Name (If not institution, give street and number) 8 Essex Court				4b. City, Town, or Ber1		eath		4c. County of Death Worcester			
Fune Direc			220 11 2002	ex 7. Age	(In yrs. last bir 81	thday)_ Yrs.	If Under 1 Year Months Days	If Under 24 H Hours N	Hrs. 8. Date of Bi Min. (Month, Da Sept 14	av. Year)	26 Mar	nplace <i>(State</i> o untry) yland	r Foreign	
Maryland a-f show	med at	ctor	Usual Residence of Decedent 10a. State 10b. County Maryland Worces	ter	10c. City, Tow	n or Loc	ation	Berl	lin			10d. Inside Cit		
h with the	ou ao is	al Director	10e. Street and Number 8 Essex Court				10f. Zip Code	2181	1	10g. Citiz	0g. Citizen of What Country? USA			
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IVICALIY IND 2 Shou alith and N 27 IS mai			19a. Informant's Name/Relationship (Type. Print) Linda Moler (Friend) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, 8 Essex Court, Berlin, Md. 21811								r Town, State, Z 1	(ip Code)		
Deficiency Pages 1 & Department of He mportant: If Item	ury or othe		1 ★ Burial 2 □ Cremation 3 □ Removal from State d□ Donation 5 □ Other (Specify) 1 ★ Burial 2 □ Cremation 3 □ Removal from State deadowridge Mem Pk 10/18/07 Elkridg								-	e, Maryland		
permit. Departi	once.	Ī	21. Signature of Funeral Service Lice	nsee Kevin E	Ecker	Mc 23	Name and Addre Cully-Po 7 E. Pat	fyniak apsco <i>A</i>	Funeral l Ave., Bal	Home, to.,	P.A. Md. 21	225-185	56	
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To the Hospital or Attend within 24 hours after death. To the Funeral Director;	npietery i	Medical	(Check only 2 Medical Exa	nysician: To the best of miner: On the basis of and manner sta	examination ar	e, death nd/or inv	estigation, in my o	pinion, death	occurred at the time	e, date and	d place, and due	to the cause(s	:)	
or with	5	_	29b. Signature and title of certifier)			29c. Licens	SY ZY			te signed (Monti			
	5		30. Name and address of person who		- track	. Ro	ad Be	rlin M	ID 2181	1				
Reg	Sta gistra		31. Date filed (Month, Day, Jear) OCT 1 7		ar's Signature	3	and .	,						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 07-07735 State of Maryland / Department of Health and Mental Hygiene William Calvin Young Certificate of Death 1- For State Reg. No. Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Month Day October 3, 2007 Physician/ 2205 hrs Medical Examiner William Calvin Young 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Washington Hagerstown 64 W. Antietam St. If Under 1 Year | If Under 24Hrs. | 8. Date of Birth(MM/DD/YYYY) | 9. Birthplace (State or unk 7. Age (In yrs. last birthday) 5. Social Security Numbelink 6. Sex **Funeral** Foreign Months Davs Hours Min 1961 Director Nov 23, 1 X M 2 F 45 Yrs Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a State 1 Yes 2 X No s 23a or 28a-f show e notified at once. Hagerstown Washington MD the Maryland Director 10g Citizen of What Country 10f. Zip Code 10e. Street and Number 21740 USA 64 W. Antietam Street 14. Race - American Indian, Black, Baltimore, MD 21215-0036
permit. Pages I and 2 should be filed within 72 hours after death with t
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a
injury or other traumatic event, the Medical Examiner must be not Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S Funeral 11. Marital Status unk If Yes, specify Cuban, Mexican, Puerto Rican, etc.) unk Armed Forces? Never Married Married Yes Specify: Yes 2 X No specify: white If Yes, Give Year 4 Divorced Widowed à 16a. Decedent's Usual Occupation (Give kind of work done ${
m unk}$ 16b. Kind of Business/Industry unk 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed College (1-4 or 5+) Elementary/Secondary (0-12) unk 18.Mother's Name (First, Middle, Maiden Surname) unk unk 17. Father's Name (First, Middle, Last) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 111 Penn Street Baltimore, MDO.C.M.E. 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Date 20a. Method of Disposition crematory or other place) Cremation 3 Removal from State Burial 2 Donation 5 X Other Specify: 22. Name and Address of Facility 21. Signature of Funeral Service Licensee State Anatomy Board 655 W. Baltimore Street Ronald 1S Director Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Between Onset and **Physician** ailure. List only one cause on each line Death /Medical Cocaine Intoxication Immediate Cause (Final disease kaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of) Examiner if any, leading to immediate sause. Either Undurly (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last The law requires that the death certificate be executed Physician/Medical X UNPENDED 28a-f per MEO G-872 10/18/07 reb AMENDED tems: 23a 27 28a 23c. If yes, outcome of p. egnancy attending physician or use as the burial -23d. Date of delivery Box 68760, IF FEMALE: Year Month Day 23b. Was decedent pregnant in the 3 Ectopic pregnancy Live birth Fetal death past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 No 9 Unknown Unknown signed by the a 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. P.O. Yes 2 No 3 Probably 4 ✔ Unknown \$ Completed Division of Vital Records, 24b. Were autopsy findings available 24a. Was an has been si prior to completion of cause of death? autopsy performed? 1 🗸 Yes No ✓ Yes 2 certificate page 26.Place of Death (Check only one) Hospital or Attending Physician: 24 hours after death Funeral Director; After this certifi 25. Was case referred to medical Be Other₄ Nursing Home 5 Residence 6 ✔ Other: Scene examiner? Hospital: FR/Outpatient 3 DOA Inpatient 2 2 No 1 V Yes 28d. Describe how injury occurred 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 1Q/3/07 10:05 p.m Certification: Yes 2 X No Unknown 1 Natural Pending Director: Found Investigation 28f. Location (Street and Number or Rural Route Number, City 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State) 64 W. Antietam St. 3 6 X Could not be Hagerstown, (Specify) Found at home determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 1 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical To the 1 within 2 To the 1 one) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier October 4, 2007 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Deputy Chief Medical Examiner Jack Titus MD 32 Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

	Physician
	/Medical
	Examiner
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Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Mcdical Examiner must be notified at once.

Baltimore, Maryland 21215-0036 **Physician** /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division or Vital Records, P.O. Box 68760,

State Registrar

	For State	State of Marylar	-	artment <i>rtificate</i>			nd M	ental Hy	•	00	007	0001	
п	Registrar 1. Decedent's Name (First, Middle, Las	(t)	06	illicate	- 01 1	Jeani		2. Date of De	Reg. N	٥	JU/	3331	
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	5. Social Security Number 6. Se	3 ()	last birthday)	If Under	1 Year	If Under 24		8. Date of Bi	th		9. Birthp	lace (State or Foreig	n
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Funeral Director	Maryland Prince George's Hyattsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What C									What Cour	1 □Yes 2 No)	
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<u>Ş</u>	3 Widowed 4 □ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2	X I No	Specify:				Speci	_{fy:} Whi	te	
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Be Completed by	17. Father's Name (First, Middle, Last)							(First, Middle		n Surna	me)		
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	19a. Informant's Name/Relationship (7	ype. Print)	19b. Maili	ng Address	(Street a	and Number	or Rura	l Route Numb	er, City	or Town	n, State, Zip	Code)	
	Krzysztof Parczews					ane,	Apt.	513,	Bet	hesd	a, MD	20814	
	20a. Method of Disposition		Place of Dispo cemetery, cre	matory or of	e of her plac	e) O	ctob	er 18,			- City or To	* '	
	Montgomery 4 Donation 5 Dother (Specify) Montgomery Crematorium, Inc. 2007 Bethesda, Maryland												
	21. Signature of Funeral Service Licensee 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue										1		
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	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between												
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2												_	
completed by Physician/in	Zob. Was decedent pregnant	23c. If yes, outcome pf pregn								23d. Date of delivery			
2	in the past 12 months? 1 ☐ Yes 2 ី No	1∐Live birth 2 ☐ Feta 4☐ Pregnant at time of c		⊒Ectopic pre ∃Other <i>(spe</i>						M	onth	Day Year	
3	9 🗆 Unknown	9□Unknown											
L 2	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the conditions contribute to the conditions contribute to the conditions contribute to the conditions contribute to the conditions contribute to the conditions contribute to the conditions contribute to the conditions contribute to the conditions contribute to the conditions contribute to the conditions contribute to the conditions contribute to the conditions contribute to the conditions contribute to the conditions contribute to the conditions contribute to the conditions conditions contribute to the conditions contribute to the conditions contribute to the conditions contribute to the conditions contribute to the conditions conditions contribute to the conditions condit										tribute to th	ne cause of death?	
ם פ	Congestive Heart Failure									ably 42 Unknow	n		
ere	Umantancian							24a. Was	an	24h	Wore auto	psy findings availabl	0
	Hypertension .							auto	psy		prior to cor death?	mpletion of cause of	6
3	Dementia							-1		0	1 ☐ Yes	2□ No	
De	25. Was case referred to medical examiner?	Hospital:			Othe			Check onl				-	_
2	1 ☐ Yes 2X No 27, Manner of Death	1 Inpatient 2 EH/Outpatient 3 DOA 4 Nursing Home 5 Residence									y)	_	
5	1 Natural 5 ☐ Pending	(Month, Day Year)	Injury	M 28	c. Injury Work			8d. Describe	now inju	ary occu	rrea		
Zal	2 Accident investigation 3 Suicide 6 Could not be	290 Place of initial At h	omo form			/es 2 □ No	-	04 1 " "					
	4 Homicide determined	28e. Place of injury - At he building, etc. (Specia	orne, rarm, str fy)	eet, ractory,	опісе		2	8f. Location (City or To			ber or Rura	l Route Number,	
5	29a. Certifier 1 X Certifying Phy	reician. To the boot of my kny	wledge deat	h occurred o	t the #-	o data and	place =	and due to #: -	001:05	0) 05-1		totad .	_
Medical Certification: 10	(Check only one)	/sician: To the best of my knoiner: On the basis of examinating and manner stated.	ation and/or in	vestigation,	in my op	ie, date and p pinion, death	occurre	ed at the time,	date a	s) and m nd place	anner as st , and due to	ated. the cause(s)	
2	29b. Signature and title of certifier	and manner stated.	_	29c.	License	number			29d. D	ate sign	ed (Month,	Dav. Year)	-
- 1		//								_		*	
	Clause.	adly, my		D4	3121	L		J.	UCL	ober	16,	2007	

DHMH 17 Rev 1/2001

Burtonsville, MD 20866

15216 Dino Dr.,

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Nurul Chowdhury, M.D.

7 2007

31. Date filed (Month, Day, Year)

Registrar DHMH 17 Rev 1/2001 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 2007 Month **Physician** Ali Ali-Rahimi 30, Sept. 8:47 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Suburban Hospital Montgomery

9. Birthplace (State or Foreign Country) Bethesda 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min. **1** M 2 □ F 167-64-4574 72 Director March 21, 1935 Iran Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 1 XYes 2 No must be notified Director Maryland Montgomery Bethesda 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 4521 East West Highway or Items 23a 20814 USA Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 🏖 No þ Specify. 3 Widowed 4 Divorced "natural", White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) than College (1-4or 5+) of Health and Mental Hygiene. item 27 Is marked other than Builder Private 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mashallah Ali-Rahimi Batoul Ali-Rahimi ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Touran Babai-Nasr (Wife) 4521 East West Highway, Bethesda MD 20814 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1 Department of the Important: If ite any injury or ot once. 1☑ Burial 2 Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) Parklawn Cemetery 10/6/2007 Rockville, MD 22. Name and Address of Facility Latimore Funeral Services, P.A. 21. Signature of Funeral Service License tallera alemo 9013 Annapolis Road, Lanham MD 20706 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Pulmoner Immediate Cause (Final disease or condition Physician resulting in death) /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of). 8:4FAM Division or Vital Records, P.O. Box 68760, by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1☐ Live birth 2☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month 5 ☐ Other (specify) dached f 1 ☐ Yes 2 ☐ No 9 Unknown Ö g Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? pe 2 No 3 Probably 4 nknown 1 Tyes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy Bage performed 25. Was case referred to medical examiner? Myper Kalemia 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA မ 27. Mann of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: After (Month, Day Year) 5 Pendina 1 Yes 2 No investigation 2 Accident in by the 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide determined Q hours To the Funeral 29a. Certifier 1 🖵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical State Registrar

Hossein Akhomdi, M.D. 8600 Old Georgetown Road, Bethesda MD 20814 32. Registrar's Signature 31. Date filed (Month, Day Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

(Check only one)

29b. Signature and title of certifier

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

13 0062 167

29d. Date signed (Month, Day, Year)

8:56 Am

Division or Vital Records, P.O. Box 68760

or Attending Physician; The law requires that the death certificate be executed

Physician

/Medical

Examiner

Funeral

Director

"natural", or items 23a or 28a-f show Idcal Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or ite may lajury or other traumatic event, the Medical Examina one.

Physician

/Medical

Examiner

Baltimore, Maryland 21215-0036

Director

Funeral

ģ

Completed

Be 2

with the Maryland

death v

Examine attending physician and Physician/Medical ģ ð Completed this certificate Be ဥ Certification: After investigation 2 Accident within 24 hours after death To the Funeral Director; 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only 29c. License number 29b. Signature and title of certifier

To the Hospital

State Registrar

29d. Date signed (Month, Day, Year)

D0057636

September 29, 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3001 Hospital Dr. Cheverly, MD 20785 Patricia Eben, M.D.

31. Date filed (Month, Day, Year)
OCT 0 3 2007

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene 2 0 0 7 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** October 8, 2007 5:55 p^M John Henry Armstrong /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** 24389 Budds Creek Road St. Mary's Clements If Under 24 Hrs. 8. Date of Birth
Hours Min. (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1 XM 2 ☐ F Director 214-18-8643 86 09/20/1921 Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits r 28a-f show notified at 1 ☐ Yes 2 X No Directo Maryland St. Mary's Clements 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or Items 23a or 24389 Budds Creek Road 20624 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠ Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 😿 No **Black** þ Specify: 3 X Widowed 4 ☐ Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed w Department of Health and Mental Hygien Important: If Item 27 Is marked other tt any injury or other traumatic event, the once. Carpet Installer Flooring 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Henry Nelson Armstrong Annie Marie Thomas 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sharon Armstrong/ Daughter 7905 Elmwood Lane, Clinton, Maryland 20735 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Burial 2 □ Cremation 3 □ Removal from State 4 Donation 5 Other (Specify) Charles Memorial Gar. 10/15/2007 Leonardtown, Maryland 21. Signature of Funeral Service License 22. Name and Address of Facility Brinsfield Funeral Home, P.A. M01403 Danielle Ward 1 22955 Hollywood Road, Leonardtown, Maryland 20650 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Dea Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner physician and is the burial-trans Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical as attending properties for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23e. Did tobacco use contribute to the cause of death? Completed by 211110 1 ☐ Yes 3 Probably 4 Unknown cate has been s , page 2 should 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy perform To the Hospital or Attending Physician: filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 2 100 1 Tes 2 ER/Outpatient 3 DOA Certification: To After this 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation (Month, Day Year) 1 Natural 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a
To the Funeral I
completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) manner stated. (Check only one) 29c. License number 29b. Signature and title of certiffs 29d. Date signed (Month, Day, Year) 9 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.D. 41860 Miss Bessie Drive, Leonardtown, Maryland 20650 Boyd, 31. Date filed (Month, Day, Year) State OCT 1 1 200 Registrar

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygienes - State Registra 33318 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death 2007 **Physician** October 8, 1545 P Gilbert Lincoln Barnett /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Laurelwood Care Center E1kton 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min 1 M 2 □ F Yrs. Director 219-28-4579 76 1931 Pennsylvania Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State item 27 is marked other than "natural", or iteme 23a or 28a-f show other traumatic event, it a Middle Examinal must be routiled at 1 ☐ Yes 2 No Directo Ceci1 E1kton Mary1and 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 43 Fox Den Drive United States 21921 death Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 █ No 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural, or item any injury or other traumatic event, the Modical Examinations. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 No Specify: Specify: B1ack 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Construction Building Contractor 8 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Leo L. Barnett Alta Brown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lucinda J. Hammond/Daughter 103 Chalice Drive, Elkton, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) October 15, Griffith AUMP Church Cem. Cedar Hill, Maryland 22. Name and Address of Facility
Hicks Home for Funerals, P.A.
103 W. Stockton St., Elkton, MD 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Altrenscleratio Physician 40013 /Medical **Examiner** Obstructive Vulmonary Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine attending physician and for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, requires that the death certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifics within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and the of certifier 29d. Date signed (Month, Day, Year) 29c. License number 11/2007 0623322 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) H 118North St & TE 3B, Elhan MD 21921. 32. Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene 2007 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** VIVIAN FORREST BROWN September 29, 2007 6:23 P /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner SOUTHERN MARYLAND HOSPITAL CLINTON PRINCE GEORGES If Under 1 Year | If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours Months Days Min. 1 □ M 2 🕱 F Sept.20, 1916 Washington, D.C. Director 578-50-6394 10a. State 10h. County 10c. City, Town or Location 10d. Inside City Limits r 28a-f sh notified a 1 Yes 2 No Maryland Prince Georges CLINTON Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? o e Items 23a cliner must b 7520 SURRATTS . 1 and 2 should be filed within 72 hours after death v Health and Mental Hygiene. em 27 is marked other than "natural", or items 23 Completed by Funeral ROAD 20735 UNITED STATES 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: BLACK 3 Widowed 4 □ Divorced Year or Dates er than "natur , the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) PRIVATE 12 HOUSEWIFE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be MARTHA YOUNG WILLIAM FORREST ۵ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 8007 ALCOA DRIVE, Ft. WASHINGTON, MD. 20744 **JOAN** BROWN HEARNS-Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages Department of h Important: If it any injury or o 1 █ Burial 2 ☐ Cremation 3 ☐ Removal from State Oct. 4, 07 Washington, D.C. 4 ☐ Donation 5 ☐ Other (Specify) Mt. OLIVET 21. Signature of Funeral Service License 22. Name and Address of Facility 5538 Marlboro Pike M00981 Pope Funeral Homes, P.A. Forestville, MD. 20747 nplications that caus y one cause on each Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or conshock, or heart failure. List or the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner certificate be executed physician and s the burial-trans Due to (or as a consequence of) P.O. Box 68760 Physician/Medical attending p IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day 4□Pregnant at time of death 5 Other (specify) the 9 Unknown 9 ☐ Unknown signed by a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy page 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 P/Outpatient 3 DOA 1 🔲 Inpatient Certification: To 28b. Time of 28a. Date of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) Injury 1 Natural
2 Accident 5 | Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director; сопріете ў illed in by the f 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital TScertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of cortified 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 11701 Livingen Rond Fort Washington, may/and 1-1ANWER MM 32. Registrar's Signature 31. Date filed (Month, Day, Year) State OCT 0 3 2007 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) September 26, 2007 11:30 p M William Henry Bannister 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Charles 3430 Baptist Church Road Nanjemoy If Under 1 Year If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year, 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Days 1**X** M 2□ F Maryland Feb.13, 1922 218-16-3154 85 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 ☐ Yes 2 No Maryland Charles Nanjemoy 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20662 U.S.A. 3430 Baptist Church Road 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black White etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: Black 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Board of Education Building Manager 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Montgomery Eva Bannister Robert 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20662 19a. Informant's Name/Relationship (Type. Print) 3430 Baptist Church Road, Nanjemoy, MAry E. Bannister Wife Date 2.2007 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Oak Grove Baptist Church 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Nanjemoy, Maryland 21. Signature of Funeral Service Licens 22 Name and Address of Facility Williams Funeral Home, P.A. 20640 M00668 Md. 4270 Hawthorne Rd., Indian Head, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or reant filture. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cau Final disease or condition resulting in death) Vas cula Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of):

Examiner requires that the death certificate be executed physician and s the bunal-trans attending properties for use as ed by the a peen

Division or Vital Records, P.O. Box 68760,

Examiner Physician/Medical þ Be Completed page 2 To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, F. Certification: To

Physician

/Medical

Examiner

Director

Funeral

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Completed

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Funeral

Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hyglene.

ant: If Item 27 Is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at

Department o Important: If any Injury or

Physician /Medical

Baltimore, Maryland 21215-0036

Cause (Disease or injury that initiated events resulting in death) Last	c				
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify)	23d. Date of delivery Month Day Year			
Part II. Other significant conditions	contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Inknown			
		24a. Was an autopsy performed? 1□ Yes 2 1 20 1 □ Yes 2 □ No			
25. Was case referred to medical	26. Place of Death	Check onlone			
examiner?	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Hom	e 5 Residence 6 Other (Specify)			
27. Manner of Death 1	(Month, Day Year) Injury Work?	Bd. Describe how injury occurred			
3 ☐ Suicide 6 ☐ Could not be determined		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier Certifying P	hysician: To the best of my knowledge, death occurred at the time, date and place, a miner: On the basis of examination and/or investigation, in my opinion, death occurre and manner stated.	nd due to the cause(s) and manner as stated. In the time, date and place, and due to the cause(s)			

29c. License number

29d. Date signed (Month, Day, Year)

State Registrar

Medical

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0 0 31. Date filed (Month, Day, Year)

OCT 0 1 200

32. Pegistrar's Signature

State of Maryland / Department of Health and Mental Hygiene 0 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year Month **Physician** Thomas Henry Brown 09 2007 0622AM /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Easton, Mary-Genesis Elder Care - The Pines Talbot Maryland 8. Date of Birth (Month, Day, Year) 08-07-1927 If Under 1 Year Months Days Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 1**Д** M 2□ F 80 Maryland Director 213-24-2531 Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State rthan "natural", or items 23a or 28a-f ahow the Medical Examinar must be notified at 1 Yes 2 No Directo Caroline Denton Md. 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21629 USA 1013 Street Gay Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Mayes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No 21215-0036 Specify: Specify: Black ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Brown's Bus Service 12 Bus Driver other other traumatic avant, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Thomas 2 should be finand Mental H Bertie Mae Nichols ပ္ Charles Emerson Brown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1013 Gay Street, Denton, Md. 21629 Alice F.Brown/ Wife Baltimore, 20b. Place of Disposition (Name of cometery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Important: If Ite
any Injury or oth 1 Burial 2 Cremation 3 Removal from State Md. Veterans Cem. 10-01-07 Hurlock, Maryland 4 ☐ Denation 6 ☐ Other (Specify) 22. Name and Address of Facility Bennie Smith Funeral Home 21. Signature of Funeral Service Licensee 426 Dover St., Easton, Md. 21601 221 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death reval disease Immediate Cause (Final disease or condition resulting in death) Physician west /Medical Due to (or as a consequence of): Examiner Heers Esquentially first conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Theros densis attending physician and for use as the burial-transit Attanding Physician: The law requires that the death certificate be executed Hears Due to (or as a consequence of) Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 2 No 1 Yes After this certification funeral director, i 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: Medical Certification: To 1 Yes 2 No Nursing Home 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Natural 5 Pending 1 ☐ Yes 2 ☐ No death. 2 Accident investigation Director: 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 - Homicide ŏ To the Hospital within 24 hours a To the Funeral I completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 Vutchmans 31. Date filed (Month, Day, Year, SEP 2 8 2007 State Registrar

			For State Registrar	State of Marylan		artment of H		l Mental ⊦	lygiene Reg. No.	2007	33322
			Decedent's Name (First, Middle, Last	st)				2. Date of	Death		3. Time of Death
	Physici /Medi		Marnette Elise	Briscoe				Octol	per 5.	2007	7:25 pm
	Examir		4a. Facility Name (If not institution, give			4b. City, Town, or	r Location of De			County of Death	
			20331 Willows Roa			Lexingte				. Mary's	
-	Funeral Director		213-40-6078	ex	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 H Hours Mi	8. Date of (Month, 04/21	Day, Year)	Cou	place (State or Foreign ntry) 'land
	pug *		Usual Residence of Decedent 10a. State 10b. County	10c. City	. Town or Lo	ocation					10d. Inside City Limits
	// Aarylan f show ed at	ō		Cons	- 4 M = 1	1 _					1 □ Yes 2X No
	the 1/28a-	Funeral Director	Maryland St. Mary	y's Grea	at Mil	10f. Zip Code			10g. Citi	izen of What Cou	intry?
	3a or	Ö	22080 Mojave Driv	e		20634			Unit	ed State	9.5
	death ms 2	ner	11. Marital Status	12. Was Decedent Ever in U. Armed Forces?	S. 13.	Was Decedent of H	lispanic Origin?	(Specify Yes or		14. Race - Ameri	ican Indian,
21215-0036	ges 1 and 2 should be filed within 72 hours after death with the Maryland to f Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	þ	1 Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	1	1 ☐ Yes 2 ŽÎNo	Specify:	erio rican, etc.)		Specify: B1	ack
5-0	72 hc 'natu	eted	15. Decedent's Ed (Specify only highest gra	lucation de completed)	16a. Dece (Give	dent's Usual Occup kind of work done DO NOT use retired	ation during most of v	vorking	16b. K	ind of Business/Ir	ndustry
2	ne. han "	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)				Ü	1	1	
2	filed withir Hygiene. other than		12 17. Father's Name (First, Middle, Last)	1	Launc	lry Super		lame (First, Mid		indry	
and	Mental I Merked of arked of	Be						Ann Gros	-		
IZ.	2 should be filed and Mental Hygi is marked other aumatic event, th	P	Joseph Briscoe 19a. Informant's Name/Relationship (Type. Print)	19b. Maili	ng Address (Street				or Town, State, Zi	ip Code)
Maryland	1 and 2 a Health an tem 27 is		Henry Briscoe/Son		20331	Willows	Road.	Lexingto	n Par	k. MD	20653
re,	s 1 a of He item othe		20a. Method of Disposition			osition (Name of matory or other place	1	Date		ocation - City or T	
E	Page nent c int: If		1 X Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specif	Removal from State Eve	rgreer orial	Gardens	10/	11/2007	Grea	at Mills	, Maryland
Baltimore,	permit. Pages 1 and 1 Department of Health In portant: If item 27 any Injury or other tr		21. Signature of Funeral Service Ucer Danielle Ward		\mathcal{O}^2	 Name and Addre 2955 Ho11 	ss of Facility	rinsfie	1d Fu	neral Ho	me, P.A.
	10 V 13		23a. Part1. Enter the disease, or com shock, or heart failure. List only	1101100						LOWII, PID	Approximate Interval Between
	Physician		Immediate Cause (Final	one cause on easy line.	Vic	Cano				4	Onset and Death
	/Medical		disease or condition resulting in death)	Due to (or as a consequ	uence of):	Carre	-er				
ь	Examiner		O and the first and the second	h							
125	.±	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consequ	uence of):						
	tate be executed obligations and the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c							
8760,	oe execian a	ñ	resulting in death) Last	Due to (or as a consequ	uence of):						
87	cate t	dical		d							
9 x	requires that the death certificate be executed een signed by the attending physician and nould be detached for use as the burial-transit	Physician/Me	IF FEMALE:	23c. If yes, outcome pf pregna	incv					23d. Date of deliv	4074
Вох	atten for u	cian	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d	Ideath 3[⊒Ectopic pregnancy ⊒ Other (specify) _	у			Month Month	Day Year
P.O.	the d y the iched	ıysi	1 ☐ Yes 2 X No 9 ☐ Unknown	9□Unknown							
	ires that signed b		Part II. Other significant conditions	ontributing to death but not resu	ulting in the u	nderlying cause giv	en in Part I.	23e. D	id tobacco i	use contribute to	the cause of death?
D	w require: been sig should be	ed by						_ 1	☐ Yes 2	□ No 3 □ Pro	bably 4 💹 Unknown
ပ္က	≥ .0 0	Completed						24a. W	as an utopsy	24b. Were aut	topsy findings available ompletion of cause of
Ä	The lav	mo						p	erformed?	death?	2 □ No
ita	ysician: The lar is certificate has director, page 2	Be C	25. Was case referred to medical examiner?				26. Place of E	Death (Check on			Canta
\ \	Physician: this certificated ral director,	2	1 ☐ Yes 2 📆 No			nt 3□ DOA Oth	4 L Nursing				Son's Residence
U C	ing P		27. Manner of Death 1 ► Natural 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	Wor		28d. Descri	be how inju	ry occurred	
Sic	Attending r death. ector: After by the fune	cati	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be		mo farm et		Yes 2 ☐ No	29f Locatio	n /Ctract or	ad Number of Bu	ral Route Number,
Division or Vital Records,	tal or Ars after cral Directed in by	Certification:	4 ☐ Homicide determined	28e. Place of injury - At ho building, etc. (Specif	y)			City or	Town, State	e)	nai Houle Nombel,
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical		nysician: To the best of my kno niner: On the basis of examina and manner stated.							
	To the To the Comp	Ž	29b. Signature and title of certifier	000		29c. Licens		~ 1		ite signed (Month	_
	An		1 -X1	100		HO	0557	21	\	0110	10+
7	12 9		30. Name and address of person who	completed cause of death (Item	23a) (Type	Print)					
			Jennifer Schmidt,	D.O. 40900 M		ts Lane,	Leonard	ltown, N	íaryla	nd 2065	50
A.	St Regist	ate rar	31. Date filed (Month, Day, Year) OCT 1 1 2								
DH	IMH 17 Rev 1/2		001115	007 Brew A	1 14	week!					

State of Maryland / Department of Health and Mental Hygiene, Reg. No. 2007 33323 Certificate of Death 3. Time of Death 2, Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** September 28, 2007 4:00 Elizabeth Brown Audrey /Medical 4c. County of Deeth 4b. City, Town, or Location of Death 4a. Fecility Name (If not institution, give street and number) Examiner MONTGOMERY ROCKVILLE HEBREW HOME OF GREATER WASHINGTON If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 10/08/1916 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1 □ M 2 F 90 NEW JÉRSEY 579-10-5066 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County rthen "naturel", or items 23s or 28s-f ehow The Medical Examiner must be notified at 1⊠Yes 2 No "NONE" DC WASHINGTON Direct 10g, Citizen of What Country? 10f. Zip Code 10e. Street and Number 20007 U.S.A. 2701 WISCONSIN AVENUE NW death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☐ No If Yes, Give filed within 72 hours after 1 ☐ Never Married 2 ☐ Married WHITE Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: þ 3 TWidowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) ACCOUNTANT U.S. GOVERNMENT 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Ith and Mental F 27 is marked of traumatic ever 99 permit. Pages 1 and 2 should be Deportment of Heelth and Mental Important: If tiem 27 is marked eny injury or other traumatic events. EDITH MAY MALEY ALBERT GARDINEER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) GEORGE GARDINEER/BROTHER 19370 MAGNOLIA GROVE SQUARE #306, LANSDOWNE, VA 21076 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 X Removal from State NATIONAL CREMATORIUM 10/1/2007 FALLS CHURCH, VIRGINIA O * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
EDWARD SAGEL FUNERAL DIRECTION, INC. 21. Signature of Funeral Service Licensee 1091 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 20852 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) Completed by Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No 1 🗌 Yes 26. Place of Death (Check only one) After this certific funeral director, 25. Was case referred to medical examiner? Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To ō 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 27. Manner of Death To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After ti completely filled in by the funera Natural 2 Accident Injury Division 5 Pending 1 ☐ Yes 2 ☐ No investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as assess.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier inic) 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.D. 6121 MONTIZOSE ROAD 32. Redistrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** /Medical Gity, Town, or Location of Death Examiner ANGa115TOWN 4/Himove if Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Social Security Number Age (In vrs. last birthday) **Funeral** Hours Min. 11XM 2□ F 216-40-7482 68 Jan, 26, 1939 Maryland Director Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show iral", or items 23a or 28a-f shov Examiner must be notified at Baltimore Catonsville 1X Yes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21228 U.S.A. 1201 Black Friars Road death by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ♣ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. filed within 72 hours after 1 □ Never Married 2 X Married Specify: Black Baltimore, Maryland 21215-0036 'naturai", or 1 ☐ Yes 2 ☐ No Specify. 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) Laborer Construction 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mable Spriggs Joseph E. Blake ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21228 19a. Informant's Name/Relationship (Type. Print) 1201 Black Friars Rd, Catonsville, MD (Wife) Pamela Tinkler Blake 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition **X**☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Nat'l Mem Park 10/2/07 Laurel, MD 5 Other (Specify) of Funeral Service V 22. Name and Address of Facility SNOWDEN FUNERAL HOME, P.A. Sign 246 N. Washington St, Rockville, MD 20850 a. Part1. Enter the shock, or hear disease, or complications one caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, immediate Cause Final disease or condi on resulting in death Onset and Death **Physician** /Medical Examiner e05100 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed bunal-transit (or as a consequence of Be Completed by Physician/Medical the as attending | for use as IF FEMALE 23c. If yes, outcome pf pregnancy 23d Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 Fetal death 3 ☐ Ectopic pregnancy Month in the past 12 months? Day signed by the at d be detached for 4 ☐ Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part il. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy pertormed? (es 2 No 1∐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2**X** No 2 ER/Outpatient 3 DOA 1 ☐ Yes 1 Inpatient Medical Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 1 Natural Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

Division or Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifical completely filled in by the funeral director, p

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State Registrar

29a. Certifier

29b. Signature and title of certifie

31 Date filed (Mon

f person who completed cause of death (Item 23a) (Type, Print) 1.0 ATKINS

1 Xcertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Pogistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death September 26, 2007 McCILLA BROWN 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Prince George's Doctors Community Hospital Lanham Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Hours Days Min. 1 □ M 2 🛣 F 62 21, 1945 North Carolina 238-70-0929 Jan. Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☑Yes 2 ☐ No Prince George's MD Lanham 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 9941 Good Luck Road #204 20706 United States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 XNo Specify: Black. 3 N Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 years Teacher Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) James Cherry Ernestine White 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 9941 Good Luck Road #204, Lanham, MD Sherrie Brown - Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Staton Memorial Garden 09/30/2007 Whitbee, N.C. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility STEWART FUNERAL HOME, Inc. ture of Funeral Service L 4001 Benning Road, N.E., Washington, D.C.20019 e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Approximate Interval Between Onset and Death 23a. Part L. Enter the disease shock, of heart failure. L. Immediate Cause (Final Metastatic cance Yr. disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions Due to for as a consuluence off cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 2 No

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

r 28a-f show notified at

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"natural", or iter adlcal Examiner

d other than "natu event, the Medical

Director

Funeral

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Completed

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Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f show

Department of Important: If it any Injury or c once,

Baltimore, Maryland 21215-0036

attending physician and for use as the burial-trar

25. Was case referred to medical examiner?

Examine

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Certification:

Medical

The law requires that the death certificate be executed To the Hospital or Attending Physician: this filled in by the within 24 hours a

Division or Vital Records, P.O. Box 68760,

State Registrar 29b. Signature and title of certifier Hachay

5 Pending investigation

6 ☐ Could not be

determined

Hospital:

29c. License number D 005 82/3

1 ☐ Yes 2 ☐ No

28c. Injury at Work?

26. Place of Death (Check only one)

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

7305 Hansver PKWY OreeleelliMD 20770 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TAMALI FARHAD MD

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

31. Date filed (Month, Day, Year) OCT 0 1 2007

1 Yes 2 No

27. Manner of Death

2 Accident

3 ☐ Suicide

29a, Certifier

4 Homicide

1 Natural

32. Registrar's Signature

1- Inpatient

28a. Date of Injury (Month, Day Year)

2 ER/Outpatient 3 DOA

28b. Time of

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 200^{Year} Ray Arthur Cline October 10 4:25 p. M 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death 2228 Michael Road Frederick Myersville If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day,) Sept. 14, 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Days 1 ☑ M 2 ☐ F Mary Land 219-34-5249

10f. Zip Code

21773

10d. Inside City Limits

10g. Citizen of What Country?

USA

1 □Yes 2□No

70

10c, City, Town or Location

Myersville

with the Maryland "natural", or items 23a or 28a-f show dical Examiner must be notified at death permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any Injury or other traumatic event, the Medical Evamina Baltimore, Maryland 21215-0036

Physician

/Medical

Examiner

Usual Residence of Decedent

2228 Michael Road

10b. County

Frederick

10a. State

Maryland

10e. Street and Number

Directo

Funeral

Director

Physician /Medical Examiner

bunial-tran physician as the use Por signed by the at d be detached for page 2 or Attending Physician; director, After within 24 hours after death.

To the Funeral Director: A completely filled in by the fu the Hospital

Division or Vital Records, P.O. Box 68760,

by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ₩ Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Maryland State Highway Elementary/Secondary (0-12) College (1-4or 5+) Maintenance Administration 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Otha Cline Viola Lelah Michael ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Betty Moser / sister 108 Ninth Avenue, Brunswick, Maryland 21716 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) St.Paul's Lutheran Oct.16, 2007 Myersville, Maryland 21. Signature Fune 22. Name and Address of Facility 504 Main Street Ricketts Funeral Home Myersville, MD 21773 011 23a. Part1. Extend the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final DIJEASE resulting in death) Due to (or as a consequence of) Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a conse Examine Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day 5 Other (specify) ☐Yes 2☐No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by MUNADO 2□No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes No 24a. Was an autopsy 25. Was case referred to medical Certification: To Be 26. Place of Death (Check only one) 20/10 Other: 4 \sum Nursing Home 1 ☐ Yes 1 Inpatient Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 28a. Date of Injury 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? (Month, Day Year) 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Lifting Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examine: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and Name and Mdr s of person who completed cause of death (Item 23a) (Type, Print) BLUD SMITHIBU 22911 Ren fersor 31. Date filed (Month, Day, Year) 32. Registrar's Signature OCT 1 7 Registrar

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

32 Registrar's Signature

Division or Vital Records, P.O. Box 68760.

within 24 h To the Fu

Melvin W. Gaskins, MD. State Registrar

(Check only one)

29b. Signature and title of certifie

7831 Belle Point Dr., Greenbelt, Md. 32. Registrar's Signat

completed cause of death (Item 23a) (Type, Print)

On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mainter as stated.

And manner stated.

29d. Date signed (Month, Day, Year)

October 2,2007

29c. License number

MD 18942

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death **Physician** Beverly Marie Katz Clokey 2007 6:40 Рм Oct /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Laurel Regional Hospital Laurel Prince George's 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Date of Birth (Month, Day, Year) Months Days Hours Min. 218-66-5126 53 1954 Washington, DC Director 25, Usual Residence of Decedent with the Maryland 10a. State 10b, County 10c. City, Town or Location 10d. Inside City Limits show 28a-f sh notified Prince George's Laure1 Director 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be r 8767 Contee Road, #302 20708 USA death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status "natural", or item edical Examiner Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ Specify: White 3 ☐ Widowed 4 ☑ Divorced Completed of Health and Mental Hygiene. Item 27 Is marked other than "natul other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) United States Dept. Elementary/Secondary (0-12) College (1-4or 5+) Management Assistant of Agriculture 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Spaulding Katz Doris Beckert ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 Is any Injury or other trau Angela Enlow/Daughter 9609 189th Street Court East, Puyallup, WA 98375 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Fort Lincoln Cemetery Oct 4, 2007 4 ☐ Donation 5 ☐ Other (Specify) Brentwood, Maryland 21. Signature of Funeral Service License 22. Name and Address of Facility 4739 Baltimore Avenue Gasch's Funeral Home, PA Hyattsville, MD 20781 Part 1. Enter the disease, or coupling flons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Aspiration Pneumonia /Medical Due to (or as a consequence of): **Examiner** Oropharyngeal Dysphagia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner the death certificate be executed burial-transit Sepsis Due to (or as a consequence of): P.O. Box 68760, ed by the attending physician detached for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month 4□Pregnant at time of death Dav Year 5 Other (specify) 9 Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ Scleroderma 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed peen Pulmonary Fibrosis 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has page 2 s autopsy performed? 2 No Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 X Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ☐ ER/Outpatient 3 ☐ DOA P this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of After t Certification: 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 24 hours after death. Injury 1 🖳 Natural 5 Pending investigation 1 Yes 2 No 2 Accident Director: the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital of within 24 hours af To the Funeral D completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 200 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Columbia, MD 21044 10724 Little Patuxent Pkwy., Suite 200 MD Kanumuru 31. Date filed (Month, Day, Year) 32. Registrar's Signatu State OCT 0 3 2007 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.? 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 2007 DOROTHY CONN BRENT OCTOBER 07:25 A M /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Montgomery General Hospital Olnev Montgomery 7. Age (In yrs. last birthday) 5. Social Security Number If Under 1 Year If Under 24 Hrs. Funeral 6. Sex 8. Date of Birth (Month, Day, Year) June 3 1912 Birthplace (State or Foreign Country) Months 1□M 2XF Min Days Hours Yrs. Director 216-78-5065 95 Missouri Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10a. State 10b. County 10c. City, Town or Location items 23a or 28a-f show 10d. Inside City Limits the Medical Examiner must be notified at Montgomery Md. Silver Spring Director 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 15310 Beaverbrook Court 20906 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 No Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2 No Specify. 2 White Specify: 3 XWidowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than ' Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wil Department of Health and Mental Hygient Important: If Item 27 is marked other the any Injury or other traumatic event, the once. 12 2 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Morie Brent Fannie Jefferies ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Betty S. Conn / Daughter 3821 Gawayne Terrace, Silver Spring, Md. 20906 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ⊠ Burial 2 □ Cremation 3 □ Removal from State Laytonsville Cem. 10/5/07 4 Donation 5 Dother (Specify) Laytonsville, Md. 22. Name and Address of Facility Muriel H. Barber Funeral Home 21. Signature of Funeral Service Licensee N P. O. Box 5038, Laytonsville, Md. 20882 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day Year signed by the a d be detached for 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 Probably 4 □Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No 24a. Was an certificate has be irector, page 2 s autopsy perforn 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Impatient 1 ☐ Yes No Other: 2 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 5 ☐ Pending investigation Natural Injury

Box 68760, Division or Vital Records, P.O. To the Hospital or Attending Physician: funeral death. after death in by the within 24 hours a

To the Funeral I

completely filled

2 Accident

6 ☐ Could not be

3 ☐ Suicide

29a. Certifier

4 Homicide

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated 29b. Signature 29c. License number 29d. Datersigned (Month, Day, Year) MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Prince HA State Registrar

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

			For State	State of Maryland / D					
			Registrar		Certificate of	Death		Reg. No.2 ()	<u> </u>
Р	Physici	an	Decedent's Name (First, Middle, La	ast)			2. Date of De Month		3. Time of Death
	/Medi			. Cavaliere	4h Cihi Taura	al antino of Da	Septem	ber 30, 2	2007 7:00 a M
	Examir	ier	4a. Facility Name (If not institution, given Arcola Health &		4b. City, Town, o		ain		
	Funeral			Sex 7. Age (In yrs. last birt.		Spring If Under 24 H	rs. 8. Date of Birt	th s	gomery B. Birthplace (State or Foreign
L	Director		577-09-1598	1□M 2\\ F 89	rs. Months Days	Hours Mi		y, Year)	Country) Nashington, DC
	p .	S)	Usual Residence of Decedent				July	,1310 1	denting con, be
	arylar show d at	_	10a. State 10b. County	10c. City, Town	or Location				10d. Inside City Limits
	ne Ma 8a-f	Director		Montgomery S:	lver Spring	g			1 □Yes 2 No
	vith th		10e. Street and Number		10f. Zip Code			10g. Citizen of Wh	at Country?
	s 23s	era		Avenue, Apt. 112		902	(2)	USA	A 2 1 - C
	item item	Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 ☑ No	13. Was Decedent of H If Yes, specify Cuba	an, Mexican, Pu	erto Rican, etc.)	Black,	American Indian, White, etc.
38	urs af	by	3 √Widowed 4 Divorced	If Yes, Give Year or Dates:	1 ☐ Yes 2√€ No	Specify:		Specify: V	White
21215-0036	2 hot	Completed	15. Decedent's E	ducation 16a.	Decedent's Usual Occup	pation		16b. Kind of Busi	ness/Industry
215	thin 7 e. an "r Med	age.	(Specify only highest gra Elementary/Secondary (0-12)	College (1-4or 5+)	(Give kind of work done life. DO NOT use retired	during most of vidit	vorking		
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$\frac{2}{3}$	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f show raumatic event, the Medical Examiner must be notified at	မ	Michael Caetto				Neumann		
Maryland	12 sh h and 7 is n traun		19a. Informant's Name/Relationship ((Type. Print) 19b. valiere/Daughter	Mailing Address (Street	and Number or	Rural Route Numbe	er, City or Town, St	ate, Zip Code) 20902
	1 and Healt em 2		20a. Method of Disposition		Disposition (Name of			20c. Location - Ci	
altimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic enonce.	,	xxxBurial 2 ☐Cremation 3 ☐	Removal from State cemeters	r, crematory or other plac		tober 3,		
Ξ	permit. Pag Department Important: any injury o	1	4 ☐ Donation 5 ☐ Other (Special 21. Signature of Funeral Service Lice		Heaven Cen		2007		Spring, Marylan
m	Department and and and and and and and and and and		2	2.	Francis Addre				
	-0		23a. Part1. Enter the disease, or com	nplications that caused the death. Do no					oring, MD 2090] Approximate Interval Between
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	/Medical		disease or condition resulting in death)	a. Sepsis Syndrome Due to (or as a consequence o					- S
	Examiner			b Urinary Tract I					
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Ď,	be executed ician and burial-transit	Ë	resulting in death) Last	Due to (or as a consequence or	f):				
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×	leath certific attending p for use as	/Me	IF FEMALE:	Office of the contract of the contract of		700			
X P P	attendation	Physician/Me	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death	3 Ectopic pregnancy	1		23d. Date of Month	
o.	the de	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at time of death 9□Unknown	5 ☐ Other (specify)				,
1	requires that the death certifi een signed by the attending I nould be detached for use as		Part II. Other significant conditions	contributing to death but not resulting in	the underlying cause give	en in Part I.	23e. Did to	obacco use contribu	ute to the cause of death?
Hecords,	w requires to been signer should be considered.	d by	Fraility. Comfort	Care, Advanced De	mentia		1 🗆 Y	/es 2 № No 3	☐ Probably 4 ☐Unknown
ပ ္ပ		Completed					24a. Was	an 24h Wa	ere autopsy findings available
Š	sician: The law certificate has b irector, page 2 s	mc	Hypertension, Fai	lure to Thrive, Re	spiratory F	ailure	 autop perfor 	psy prior pr	or to completion of cause of ath?
VITal	an: T tificat or, pa		25. Was case referred to medical			26 Plans of D	1 Yes leath (Check only o		Yes 2□No
	Physician: this certific ral director,	o Be	examiner? 1 ☐ Yes 2 ☐ X No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Out	patient 3 DOA Oth		Home 5 Resid		(Specify)
0	ig Phys ter this neral dii	n: T	27. Manner of Death	28a. Date of Injury 28b. Ti	me of 28c. Injur			now injury occurred	
UIVISION	ath. arth. ar: Aff	atio	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	n	· 1	Yes 2 □ No			
<u> </u>	er der recto	Certification:	3 Suicide 6 Could not be 4 Homicide determined		n, street, factory, office		28f. Location (S City or Tow	Street and Number	or Rural Route Number,
2	ital or saft ral Di	Ş							
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	ca	(Check only 2 Medical Exar	hysician: To the best of my knowledge, miner: On the basis of examination and	death occurred at the tir	me, date and pla	ice, and due to the	cause(s) and mann	er as stated.
	the hin 2 the l	Medical	one)	and manner stated.					
			29b. Signature and title of certifier	msmear	29c. License D533		1	29d. Date signed (i Octobe:	
	3								,,
			30. Name and address of person who Rajan Shyamsund	completed cause of death (Item 23a) (Tdar, MD 9801 Geo	^{ype, Print)} rgia Avenue	, #117.	Silver S	Spring. M	D 20902
9/2	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Signature					
	Registr	ar	OCT 0.3.2	2007 🔉	1				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	State of Ma	ryland /		artment of H		Mental Hy	•	000-	000	0.0
	S	v	Registrar 1. Decedent's Name (First, Middle, La	st)		Cer	illicate of I	Dealli	2. Date of De	Reg. No	2001	3. Time of D	eath
	Physicia		Mary Crawford	,					Month Septem	be $\mathbf{r}^{^{Da}}$	29, 200	7 10:3	
	/Medic Examin		4a. Facility Name (If not institution, giv	e street and number)			4b. City, Town, or	Location of Death	1	40	. County of Dea	th	
			401 Sherbrook D		(In um last l	h inthodos ()	Silver	Spring If Under 24 Hrs.	Doto of Bir	rth		omery	Form into
	Funeral Director		5. Social Security Number 6. S 220-44-7615	1 M 2 F 7. Age	i (In yrs. last t 79	Yrs.	Months Days	Hours Min.	8. Date of Bir (Month, Da April 3	ay, Year 19	928 Eng	thplace <i>(Stat</i> e o <i>r I</i> p <i>untry)</i> ¡ lan d	-oreign
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. City, To	wn or Lo	cation					10d. Inside City	Limits
	Manyli f sho	ţor	Maryland Mon	tgomery	S	ilve	r Spring					1 □Yes 2	No 🍱
	n the	irec	10e. Street and Number				10f. Zip Code			10g. Ci	tizen of What C	ountry?	
	23a c ust be	ra D	401 Sherbrook D	rive			20904				USA		
220	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3℃Widowed 4 □ Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 22. N If Yes, Give Year or Dates:			Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 No	lispanic Origin? (S an, Mexican, Puert Specify:	pecify Yes or No o Rican, etc.)	0-	14. Race - Ame Black, Whi Specify:Whi	te, etc.	
0-017	vithin 72 ho ine. han "natur e Medical I	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12)	ducation ade completed) College (1-4or 5-		(Give life. I	dent's Usual Occup kind of work done o DO NOT use retired	ation during most of wor d)	rking	16b. K	Control II		
7	filled w Hygie ther t		17. Father's Name (First, Middle, Last			п	omemaker	18, Mother's Nan	ne (First, Middle	, Maider	Own Hom	ie	
ylall	ould be i Mental narked o	To Be	Charles Watson	Boise	La			Hazel C	rawford	Boi	Lse	T. 0 11	
<u>Z</u>	d2sh thand than		19a. Informant's Name/Relationship (Robert C. Cifell	,			ng Address <i>(Str</i> eet Silverlea					,	
טֿ	s 1 an f Heal tem 2 other		20a. Method of Disposition		20b. Place	of Dispo	sition (Name of matory or other place	i	Date ber 2		ocation - City or		
al[]][]	ment o		1 ☐ Burial 2 【X*Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci	fy)		opol	itan Crem	natory	2007		ober 2,		
מ	permit Depar Impor any in once.		21. Signature of Juneral Service Lice	nsee Lig			Francis J 500 Unive						090
b	- 500		23a. Part1. Enter the disease, or con shock, or heart failure. List only	iplications that caused one cause on each lin	the death. D							Approximate Interval Betwee Onset and De	een
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	- u			ardiovasc	ular Dis	ease			Offset and De	
	Examiner			Due to (or as a	a consequenc	e ot):							
	p ±	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury	Due to (or as a	a consequenc	e of):							
_	ecute and I-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c Due to (or as a	a consequenc	e of):							
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.O. DOX	To the Hospital or Attending Physician: The law requires that the death certificathin 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending prompletely filled in by the funeral director, page 2 should be detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome p 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal dea		⊒Ectopic pregnancy ⊒ Other <i>(specify)</i>	<i>y</i>			23d. Date of de Month	Day Ye	ar
r V	es thai gned t		Part II. Other significant conditions	contributing to death bu	ut not resulting	in the u	nderlying cause giv	en in Part I.				o the cause of dea	
ecolos,	requir een si hould	ted	Chronic Obstruct	ive Pulmona	ary Dis	seas	e,				2 No 3 F	Probably 4XIXUn	known
	The law ate has b page 2 sl	Completed by	<u>Crohn's Disease</u>							opsy ormed?	prior to death?	utopsy findings av completion of cau s 2 □ No	
אונס	ician: Sertific ector,	Be	25. Was case referred to medical examiner?	Hospital:			ot 3 DOA Oth	26. Place of Dea					
5	Phys r this ral dir	- To	1 ☐ Yes 2 ☑ No 27. Manner of Death	1 ☐ Inpatier	nt 2 ER/0	Outpatier o. Time o	IL SELDON	4 Nursing F	lome 5 🔀 Res 28d. Describe		6 □Other (Sp	ecify)	
NISIOI NISIOI	nding th. :: After e fune	rtion	1 X Natural 5 ☐ Pending 2 ☐ Accident investigatio	(Month, Day		Injury	Wor	k? Yes 2 □ No	2001 20001120	Tion inje	ary coodinod		
	after dea Director	Certification:	3 ☐ Suicide 6 ☐ Could not be determined		ury - At home, c. (Specify)	farm, str	reet, factory, office		28f. Location City or To	(Street a own, Stat	and Number or F te)	Rural Route Numbe	e <i>r</i> ,
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director, I	Medical C		hysician: To the best of miner: On the basis of and manner sta	examination								
	To the within comp	Me	29b. Signature and title of certifier	bruze uni	MD		29c. Licens			29d. Da	ate signed (Mor	th, Day, Year)	
	10		30. Name and address of person who	completed cause of de	eath (Item 23a	a) (Type,	Print) 7	The De	RSHIN	IG-	Drive	22001	
	Sta Registr		31. Date filed (Month Per Your) 3	2007 32. Figistra	ar's Signature	2 6	Carti		26.14.1	<u> </u>	1-01	, ===//	
	32					-	-						

DHMH 17 Rev 1/2001

DHMH 17 Rev 1/2001

State

Registrar

Rashid Baghai, M.D

2007

31. Date filed (Month Day,

ggistrar's Signature

344 University Blvd, W, #344, Silver Spring, MD 20901

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

07:23 MAM

Year

29d. Date signed (Month, Day, Year)

07

DHMH 17 Rev 1/2001

State

Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

In eccids 40

JUI CHIH HSW, MD

OCT

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2007

22-3

West main st

29c. License number

D04823

Elleta 4d 2192

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

certificate has been signed by the attending physician and rector, page 2 should be detached for use as the burial-tran 20655 Am Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 09/30/07 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 Renal Failure, Chronic Kidney Disease, Completed CVA, Hyperlipidemia Dixon, Eunice, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 1 ☐ Yes 💥 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No To the Hospital or Attendli within 24 hours after death. To the Funeral Director: A 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 ☐ Homicide *CPCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29c. License number 29b. Signature and title of contifier D60017

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

Arlington, Virginia Approximate 20901 Interval Between Onset and Death Chronic 23d. Date of delivery Month Day 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 【XNo 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 1 ☐ Yes 2 ☐ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) 29d. Date signed (Month, Day, Year) October 1, 2007

Year

9. Birthplace (State or Foreign

10d. Inside City Limits

1 ☐ Yes 2X No

Maryland

State Registrar

Eric Park,

1 - For State Registrar

egistrar's Signature

8600 OLd Georgetown Road, Bethesda, MD 20814

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** coll AM Dorsev 2007 *October* /Medical 4c. County of Death Facility Name (If not institution, give street and number) Town, or Location of Death Examiner River hester town Kent Hospital If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Nov 24 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Year 1**X** M 2□ F Maryland 1936 70 Director 213-34-4174 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County show ral", or items 23a or 28a-f shov Examiner must be notified at 1 X Yes 2 No Greensboro |Maryland Caroline Director 10g. Citizen of What Country? 10f Zip Code 10e. Street and Number 21639 USA 109 Maple Ave Funeral 14 Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 72 hours after 1 Yes 2 If Yes, Give 2□No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify. Completed by Specify: White 3 ☐ Widowed 4X Divorced "natural" 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry the Medical filed within 7 Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) is marked other than Caroline County maintenance supervisor 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be filt Department of Health and Mental H Important: If item 27 is marked oth any linjuy or other traumatic event ones. 17. Father's Name (First, Middle, Last) Be Lurena Miller Aubrey E. Dorsey 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 218 Pilgrim Circle; Wilmington, NC 28401 John E. Dorsey-Graham/son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crema 10/9/07 Chester, Maryland 21. Signature of Fugeral Service Licensee 22. Name and Address of Facility Fleegle and Helfenbein Funeral Home, PA 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final to (or a a consequence of): **Physician** disease or condition resulting in death) /Medical Due to (or a Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed physician and the burial-tran Due to (or as a consequence of) Physician/Medical as attending IF FEMALE: nse 23c. If yes, outcome pf pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy for Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 9☐Unknown 5 Other (specify) ate has been signed by the page 2 should be detached 9 Unknown significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate has autopsy perform to bra Flync | 1 Yes 2 [26 Place of Death (Check only one) or Attending Physician: 25. Was case referred to medical examiner? Be (funeral director, Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 th Certification: To After this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation s after death.

Il Director: Af

id in by the fur 1 Tyes 2 🗌 No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical

Box 68760, P.O. Division or Vital Records, within 24 hours at To the Funeral C completely filled i Hospital the

> State Registrar

31. Date filed (Month, Day, Year) 0 9 2007

K

(Check only

29b. Signature and title of certifier



and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

10 AS

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland 7 Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 2007 10:55 P M 09 $2\bar{0}$ THOMAS DUNN, JR. /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner MONTGOMERY WASHINGTON ADVENTIST HOSPITAL SILVER SPRING 8. Date of Birth (Month, Day, Year) 10/03/1943 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1**X** M 2□ F KINSTON, NC 577-58-7104 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 23a or 28a-f show notified at ¹X Yes 2 No Directo HYATTSVILLE PRINCE GEORGES MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or any injury or other traumatic event, the Medical Examiner must be a USA 9272 ADELPHI ROAD #104 20783 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1∰Yes 2 □ No If Yes, Give Year or Dates: ARMY 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2XXMarried Specify: BLACK Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: ð 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) AUTOMOTIVE PARTS SPECIALIST PRIVATE 11TH 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) MARTHA DAYS Martha McLain THOMAS DUNN, SR. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 9272 ADELPHI RD. #104 HYATTSVILLE, MD 20783 GAILA DUNN/WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 → Burial 2 □ Cremation 3 □ Removal from State 09/27/2007 LAUREL, MD MARYLAND NATIONAL 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME 21. Signature of Funeral Service Licensee 7474 LANDOVER ROAD LANDOVER, MD 20785 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attending Physician; The law requires that the death certificate be executed for use as the burial-transit and Due to (or as a consequence of) ed by the attending physician detached for use as the buria Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4□Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown s been signed by the should be detached 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy performed? Yes 2. No this certificate 1□ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Inpatient 2 ER/Outpatient 3□ DOA Medical Certification: To 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After (Month, Day Year) Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation death. after death. 2 ☐ Accident filled in by the 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the Hospital within 24 hours a To the Funeral C crifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed caus

State Registrar 31. Date filed (Month, Day, Year)

OCT 0 1 2007

32. Registrar's Signature

HANOVER PARKURS COREENBE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygien Certificate of Death Reg. No. 3. Time of Death 2. Date of Death Decedent's Name (First, Middle, Last) Month **Physician** 2:40 PM SEPTEMBER 24 2007 VICKI LYNN ELLIS /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a, Facility Name (If not institution, give street and number) **Examiner** TALBOT 29334 DOGWOOD VIEW DR. CORDOVA If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, Birthplace (State or Foreign Country) 6. Sex 7. Age (In vrs. last birthday) 5. Social Security Number 12, Year **Funeral** Months 1 □ M 2**X**1 F Yrs. AUG. 1966 D.C. Director 218-94-8903 Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10b. County 10c. City. Town or Location 10a. State ir than "naturel", or items 23a or 28a-f ehow the Medical Examiner must be notified at 1 Yes 2 No Director **CORDOVA** MD TALBOT 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number 29334 DOGWOOD VIEW DR. 21625 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2 X No Specify: Specify: WHITE ģ 3 Widowed 4 Divorced Be Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) I.T. SPECIALIST U.S. NAVY 0 Pages 1 end 2 should be filed w trans of Heatth and Mental Hygie trant: if item 27 is marked other t hury or other traumatic event, IL Maryland 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) SANDRA HOYLE ROBERT ALLEN BOYER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 29334 DOGWOOD VIEW DR., CORDOVA, MD 21625 ROBIN L. ELLIS/HUSBAND Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1
☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) permit. Page Depertment o important: if any injury or once. WOODLAWN MEMORIAL PARK 10/1/2007 EASTON, MARYLAND 21. Signature of Funeral Service Licensee 22. Name and Address of Faci FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA JUHN R. MERCERO 200 S. HARRISON ST., EASTON, MD 21601 Approximate 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) BREAST CANCER **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine physicien end the burlal-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. Physician/Medical ettending p IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) P.0. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 1 Yes 2 No this certificete To the Hospital or Attending Physician: After this certification funeral director, 25. Was case referre medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 🔀 Residence 6 ☐ Other (Specify) 2 🗹 No Certification: To 1 🗌 Yes 27. Manny of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending To the nosponeration death.

To the Funerei Director: All 1 ☐ Yes 2 ☐ No death. investigation 2 Accident 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, lactory, office building, etc. (Specify) 28l. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title certitie un 06 6-9 person who completed cause of death (Item 23a) (Type, Print) 30. Name and address 6 P-# 115 Sel1.H James 50-(01-SEP 2 32. Figistrar's Signature State Registrar

DHMH 17 Rev 1/2001

State Registrar

Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Dav **Physician** 09 26 1:39 0++ 2007 /Medical 4a. Facilify Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 5 DU CU If Under 24 Hr Pice at Lake omico ocial Security Number 7. Age (In yrs. last birthday) If Under 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🕇 F Days 231-68-6570 Director 60 2/12/1946 Georgia Usual Residence of Decedent death with the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglent Department of Health and Mental Hyglent "Inatural", or Items 23a or 28a-f show Important: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at Director 1 □Yes 2 TvNo Maryland Somerset Westover 10e, Street and Number 10g. Citizen of What Country? 10f. Zip Code 30710 Rehobeth Road 21871 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 📉 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify. þ 3 ☐ Widowed 4 X Divorced white Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) cashier convenience store 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Olin Murphy P Kathleen Hunt 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Terry Elliott/ex-husband 3203 Hessney Dr., Falls Church, VA 22402 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Salisbury Crematory 10/1/07 Salisbury, MD 21. Signature of Funeral Service Licensee Thomas and Address of the Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 Runa 23a. Part1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner The law requires that the death certificate be executed that initiated events resulting in death) Last burial-trai Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9∏Unknown 9 Unknow signed t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Tyes 3 Probably 4 ☐ Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has perform To the Hospital or Attending Physician: 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only of Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: ို 1 Yes 2 ☐ ER/Outpatient 3 □ DOA **Copatient** this 28a. Date of Injury (Month, Day Year) 27. Manger of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification; 5 Pending investigation Natural 2 Accident Injury 2 No 1 ☐ Yes after death Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only one) 29c. License number 29b. Signature and title of certifier . Name and address of person who completed cause of death (Item 23a) (Type, Print) trar's Signature State

Registrar
DHMH 17 Rev 1/2001

			For State Registrar	State of Ma	ryiand /	•	tificate of		ia ivient	, ,	. No.	00042
	A.T.	ţ.	1. Decedent's Name (First, Middle, La	st)						ate of Death	Day Year	3. Time of Death
B	Physici /Medic		George Purnel	ll Freder	ick, S	Sr.					8, 2007	5:42 p ^M
	Examin		4a. Facility Name (If not institution, give	e street and number)			4b. City, Town, o	r Location of E	Death		4c. County of Dea	th
			20815 Abell Road				Abell				St. Mary	r†s
4	Funeral		Social Security Number 6. S	ex 7. Age	(In yrs. last b		If Under 1 Year Months Days			ate of Birth Month, Day, Y	(ear) 9. Bir	thplace (State or Foreign ountry)
Ęú.	Director		216-12-4664	AW ZLIF	85	Yrs.			30	8/25/19	922 Mar	yland
	pud *		Usual Residence of Decedent 10a. State 10b. County		10c. City, To	wn or Lo	cation	-				10d. Inside City Limits
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	he M 28a-f otifie	Director	Maryland St. Mary	7'S	Abel1	-	405 75 0 1				0.11	**
	with the be n	흅					10f. Zip Code			109	j. Citizen of What Co	ountry?
	s 23	Funeral	20815 Abell Road	12. Was Decedent E	vor in II C	10.1	20606		-0 /0		nited Sta	
	ter de	in.	11. Marital Status1 ☐ Never Married 2 ☒ Married	Armed Forces?		13. 1	Vas Decedent of H f Yes, specify Cuba	an, Mexican, F	Puerto Ricar	n, etc.)	Black, Whit	
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Ş	fled within 72 hours after death with the Maryland Hygiene. other than "natural", or items 23a or 28a-f show ent, the Medical Examiner must be notified at		15. Decedent's Ed	lucation		a Decer	ent's Usual Occup	ation		16	ib. Kind of Business	/Industry
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D	othe rent,	BeC	17. Father's Name (First, Middle, Last,)	, ,			18. Mother's	s Name (Firs	st, Middle, Ma	iden Surname)	-
a	led be lenta rked ric ev	To B	John Frederick					Catl	herine	Lena	Thomas	
Maryland 21215-0036	should and Men s marke umatic	-	19a. Informant's Name/Relationship (Type. Print)	19	b. Mailin	g Address (Street				City or Town, State,	Zip Code)
	ges 1 and 2 should be filed within 72 hours after death with the Marylan it of Health and Mental Hygene. If item 27 is marked other than "natural", or items 23a or 28a-f show are or other traumatic event, the Medical Examiner must be notified at		Rita Frederick/W	ife	2	0815	Abell Ro	oad. At	bell.	Marvla	nd 20606	
ē,	s 1 a		20a. Method of Disposition		20b. Place	of Dispo	sition (Name of natory or other place	ce)	Date		c. Location - City or	Town, State
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Baltimore,	+ E ta :=		21. Signature of Funeral Service 1999		Judic	22	. Name and Addre	ss of Facility	Brins	field	Funeral H	ome. P.A.
ñ	Depa Impo any I		Edward W. Brins	sfield, Jr.	м0005						dtown, MD	
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	e dea he at led fo	sici	1 ☐ Yes 2 ☐ No	4☐Pregnant at 9☐Unknown	time of death	5 □	Other (specify)				Month	Day Year
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<u> </u>	I or Atten after death Director:	Certification:	4 Homicide determined	28e. Place of inju building, etc	ry - At home, (<i>Specify</i>)	farm, stre	eet, factory, office			ocation (Stre Sity or Town, S	et and Number or R State)	ural Route Number,
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	To the Hospital or Attending Physician: within 24 hours after deals. To the Funeral Director: After this certific completely filled in by the funeral director,	edical	29a. Certifier Check only one) Certifying Ph	ysician: To the best on the basis of	examination a	ge, deatr and/or in	occurred at the tire estigation, in my d	me, date and p opinion, death	place, and d occurred at	ue to the cau the time, date	se(s) and manner a e and place, and du	s stated. e to the cause(s)
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	Sta Registr			007	H	1	ollywo					
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DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

OCT 0 3 2007

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For State Registrar	State of M	laryland / [artmen tificate			and Me		giene Reg. No	Z 11 11 1	33344	ł
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	/Medio		4a. Facility Name (If not institution, gi			GI		Town, or	Location of		CLOBE		. County of Dea		
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	Funeral Director			Sex 7. A 1∭2 M 2 □ F	ge (In yrs. last bir 83	rthday) Yrs.	If Under Months		Hours Hours	Min	B. Date of Bird (Month, Da Sept.	y, Year)	9. Bir Cc 1924 Ne	thplace (State or Foreign ountry) W York	7
			Usual Residence of Decedent		00						ерг.	20,	1924 NE	W IOLK	_
	ith the Marylan or 28a-f show or todiffed at	'n	10a. State 10b. County		10c. City, Tow									10d. Inside City Limits 1 ☐ Yes 2 🕅 No	
	the M	Director	Maryland Cecil 10e. Street and Number	w	Elk	ton	10f. Zip	Code				10a. Cit	izen of What Co		_
	ath with the Maryla 23a or 28a-f show	al Di	20 Joseph Gallal	ner Street								_	ited St	-	
	tems terms	Funeral	11. Marital Status	12. Was Decedent Amed Forces	?	13. V	Vas Deced f Yes, spec	lent of His	spanic Origin, Mexican	gin? (Speci	fy Yes or No can, etc.)	-	14. Race - Ame Black, Whit		
36	irs afte	by F	1 ☐ Never Married 2 🛣 Married 3 ☐ Widowed 4 ☐ Divorced	1 (X) Yes 2 ☐ If Yes, Give Year or Dates:	№ 1943- 1945	1	I□Yes 2	2∭ No	Specify:				Specify: V	white	
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	To the Hospitel or Attending Physicien: The la within 24 hours after death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2	edical	29a. Certifier 1 Certifying Pl (Check only one) 2 Medical Exa	hysician: To the best miner: On the basis o and manner st	of examination an	d/or inv	occurred a estigation,	at the time in my opi	e, date and inion, deat	d place, and	d due to the o at the time, o	cause(s) date and	and manner as place, and due	stated. to the cause(s)	
	To th within To th comp	Me	29b. Signature and title of certifier				29c.	License	number			29d. Dat	te signed (Mont	h, Day, Year)	_
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	15/1		30. Name and address of person who	completed cause of c	death (Item 23a) ((Type, F	Print)	, 5	LKT	v~ . t	10-21	921			
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legiple, State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Physician September 3:20PM Harry Lee Gray, II 30 2007 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b City Town or Location of Death Examiner Medical Center MD naries Plata 9. Birthplace (State or Foreign Country) 1945 Washington DC Year If Under 24 Hrs. 8. Date of Birth (Month, Day, YApril 2, 7. Age (In vrs. last birthday 5. Social Security Number 6. Sex **Funeral** Days Year Hours 1 XM 2 ☐ F Yrs. 62 Director 578-56-1489 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits 10b. County Show "natural", or Items 23a or 28a-f shov idical Examiner must be notified at 1 ☐ Yes 2X No Director Titusville Florida Bevard 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 32780 1200 Labrea Avenue USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc. 1 X Yes 2 No If Yes, Give Year or Dates: 1963-67 1 ☐ Never Married 2 🔀 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 🗓 No Specify: Specify: þ 3 Widowed 4 Divorced Completed Injury or other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) Clerk US Government I and 2 should be filed whealth and Mental Hygier and 27 is marked other the 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Harry Lee Gray Marie Louise Ruth ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s
Department of Health ar
Important; If item 27 is 1
any Injury or other trau Patricia M. Gray - Wife 1200 Labrea Ave., Titusville, Florida 32780 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State MD Veterans' Cemetery 10-9-07 Cheltenham, MD 4 □ Donation 5 □ Other (Specify) M00053 22. Name and Address of Facility 3035 Old Washington Road 21. Sign surve of Funeral Service Licens Huntt Funeral Home Waldorf, MD 20601 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Emphy Sehic **Physician** /Medical Due to (or s a c sequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner certificate be executed burial-tran Due to (or as a consequence of): Box 68760. nding physician Physician/Medical the use as t IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) P.O. 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 12 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has le 2 autopsy performe page 1□ Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No P 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Menner of Death 1 Natural 2 Accident 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: After 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No To the Hospital or Attence within 24 hours after death To the Funeral Director: filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Płace of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

State Registrar 29a. Certifier

one) 29b. Signature and title

(Check only

31. Date filed (Month, Day, Year)

of certifier

OCT 0 2

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Paistrar's Signature

Ansari M.D.

2007

Medical

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DHMH 17 Rev 1/2001

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

7- E Post Office Road Waldorf, MD

D-00053219

29d. Date signed (Month, Day, Year)

Physician

/Medical

Examiner

Funeral

Director

show

or Items 23a or 28a-f shovaminer must be notified at

"natural",

tem 27 is marked other

permit. Pages 1 and Department of Health Important; if item 27 any Injury or other troops.

Completed

Be

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

Baltimore, Maryland 21215-0036

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year RICHARD A. GRAHAM 24 2007 SEPTEMBER 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death 24C96 DEEP NECK ROAD ROYAL OAK TALBOT 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) NOV. 6, 1920 6. Sex Birthplace (State or Foreign Country) Days Months Hours 1**X** M 2□ F 86 397-05-3759 ILLINOIS Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2 🗖 No Director TALBOT ROYAL OAK 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 24096 DEEP NECK ROAD 21662 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 TYes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify. 1 ☐ Yes 2 No þ Specify: 3 ☐ Widowed 4 ☐ Divorced WHITE 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4or 5+) 5+ Elementary/Secondary (0-12) 12 **EDUCATOR** COLLEGE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) LOUIS A. GRAHAM ESTELLE STONE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) NANCY GRAHAM/WIFE PO BOX 87, ROYAL OAK, MARYLAND 21662 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2X Cremation 3 Pemoval from State CHESAPEAKE CREMATION CTR. 9/26/2007 STEVENSVILLE, MD 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA 200 S. HARRISON ST., EASTON, MD 21601 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final enebro unicular 4 day disease or condition resulting in death) Due to (or as a consequence of) Due to (or as a consequence of)

Physician /Medical Examiner

physician and s the burial-trans

signed by the attending p d be detached for use as

certificate has I

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filled in by the fi

within 24 hours a To the Funeral L

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Certification:

Medical

The law requires that the death certificate be executed

To the Hospital or Attending Physician;

Division or Vital Records, P.O. Box 68760,

Examiner Physician/Medical IF FEMALE: à Completed Be

Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last

23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No

4☐Pregnant at time of death

Due to (or as a consequence of):

3 ☐ Ectopic pregnancy 5 Other (specify)

23d. Date of delivery Month

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown

Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

28a. Date of Injury (Month, Day Year)

24a. Was an autopsy performed 1∐ Yes 26. Place of Death (Check only one)

28c. Injury at Work?

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 No Other: 4 Nursing Home 5 Nesidence 6 Other (Specify)

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ 10 27. Manner of Death

5 ☐ Pending investigation 1 Natural 2 Accident 6 Could not be determined 3 ☐ Suicide 4 Homicide

1 Yes 2 No 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

1 Inpatient 2 ER/Outpatient 3 DOA

28b. Time of

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

(Check only 29b. Signature and title of certifier

29a. Certifier

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Hospital:

J./EGLSEDÉR, LUDWIG III, M.D. 503 CYNWOOD DRIVE, EASTON, MD 21601

State Registrar 31. Date filed (Month, Day, Year) SEP 2 7 2007 32 Registrar's Signature

G+VA

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amend #51- State Registrar Certificate of Death Registrar FH_TCHD_10/09/2007, pha 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** ALICE EDITH GEIB SEPTEMBER 26 2007 11:38 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner MEMORIAL HOSPITAL @ EASTON TALBUT EASTON 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (St. Country)
APR. 22, 1921 MARYLAND 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 3-24-4682 1 □ M 2 X F Yrs. 86 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. 10b. County 10c. City, Town or Location a or 28a-f show be notified at 10a. State 10d. Inside City Limits 1 □ Yes 2X No Director MD TALBOT CORDOVA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9825 COUNCELL ROAD "natural", or items 23a 21625 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black. White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: WHITE þ XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 8 0 HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 FANNIE E. TRICE HERMAN HENRY ANDREWS 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) S LU ANN FISHER/DAUGHTER 9821 COUNCELL ROAD, CORDOVA, MARYLAND 21625 Important: If item 2 any Injury or other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 N Burial 2 □ Cremation 3 □ Removal from State 4 Donation 5 ☐ Other (Specify) FAIRVIEW CEMETERY 10/03/2007 CORDOVA, MARYLAND 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA
200 S. HARRISON ST., EASTON, MD 21601 21. Signature of Funeral Service Licensee NOHO R. MERCERON 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Congestive heart **Physician** 2700 /Medical Due to (or as a consequence of): **Examiner** pertension Sequentially list conditions, If any, leading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Exami physician and s the burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical the SB IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 1 | Yes 2 | 10 2 ER/Outpatient 3 DOA 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 19051172 3 30. Name and address of person who completed cause of death (item 23a) (Type, Print)

Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

JORGE ABREGO, M.D. 598 CYNWOOD DR., EASTON, MD 21601

			1 - State Registrar		tment of Health a ificate of Death	nd Mental Hy	/giene 007	33348
	Physici	an	1. Decedent's Name (First, Middle, Last)			2. Date of De Month	Day Year	3. Time of Death
	/Medic	al	Donald P. Hall			Octobe		12:30A M
	Examin	er	4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of	Death	4c. County of Dear	'n
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Registra DHMH 17 Rev 1/2001

State

Matthew L. Davis,

OCT 0 3 2007

31. Date filed (Month, Day, Year)

ress of person who completed cause of death (Item 23a) (Type, Print)
W L. Davis, M.D. 22 S. Greene St. Baltimore, Md 21201

2. Registrar's Signature

Year

Sept.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieney Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Day Year Mary Agnes Hill October 04 2007 7:30 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death charles Civista if Under 1 Year 8. Date of Birth (Month, Day, Ye June 16, Birthplace (State or Foreign Country) **Funeral** 1 M 2 X F Year 213-54-6871 93 1914 Director Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at Maryland St. Mary's Chaptico 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 24909 Hurry Road 20621 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 ☐ Never Married 2 ☐ Married $\mathcal{M}_{\mathcal{A}}\mathcal{R} \vee \mathcal{H}_{i}$ 4.4 Baltimore, Maryland 21215-0036 1 ☐ Yes 2K No Specify White Completed by Specify: 3 X Widowed 4 ☐ Divorced Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Cafeteria Worker Public School 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Joseph Henry Alvey Frances Geneive Jones 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Allen Henry Hill / Son 24895 Hurry Road Chaptico, MD 20621 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 m Burial 2 ☐ Cremation 3 ☐ Removal from State October 9, Queen of Peace Cemetery 4 Donation 5 Dother (Specify) Helen, Maryland 2007 21. Signature of Funeral S. Puic, Livensee 22. Name and Address of Facility Mattingley-Gardiner Funeral Home, P.A. P.O. Box 270 Leonardtown, MD 20650 23a. Part1. Enter the disease or complications that caused the coath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each time. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or a nsequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, attending physician Physician/Medical IF FEMALE: nse If yes, outcome pf pregnancy 1 □Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown 4 ☐ Pregnant at time of death Month Day Year 5 ☐ Other (specify) Records, P.O. the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably page 2 should Completed 24b. Were autopsy findings available pnor to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy perform Division or Vital 1□ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) examiner?
1 ☐ Yes 2 X No
27. Manner of Death Hospital: Other: 4 Nursing Home 1 Inpatient ို 2 ER/Outpatient 3 DOA this 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 28h Time of After t 28c. Injury at Work? Certification: 28d. Describe how injury occurred To the Hospital or Attending 1 Naturai 2 Accident 5 Pending investigation thin 24 hours after control of the Funeral Director: After a control of the funeral by the funeral of the funer 1 ☐ Yes 2 ☐ No 3 ☐ Suicide 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) manner stated 29b. Signature and title of certified 0 29c. License number 006 652

DHMH 17 Rev 1/2001

State

Registrar

Suite 304

address of person who completed cause of death (Item 23a) (Type, Print)

Katyal

OCT 0 9 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Mary Catherine Harding Tobes /Medical Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 213-50-9247 1 □ M 2 🗓 F 81 Director February 8, 1926 Maryland Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits "natural", or items 23a or 28a-f show edical Examiner must be notifled at St. Mary's Maryland 1 ☐ Yes 2 ☑ No Director Mechanicsville 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 27625 Mechanicsville Road 20659 Pages 1 and 2 should be filed within 72 hours after death vent of Heatth and Mental Hygiene. nt: If Item 27 is marked other than "natural", or Items 23s USA Funeral 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🖾 No Specify. White Specify: Be Completed by 3 XWidowed 4 ☐ Divorced Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry other traumatic event, the Medical Maryland 2121 Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) William Ford Wathen Katherine Harden ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 27625 Mechanicsville Road nt of Health a t: If Item 27 is y or other trai Mechanicsville, MD 20659 Joseph Leo Harding / Son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department o Important: If any in]ury or r 12, October St. Joseph's Cemetery 4 Donation 5 Dother (Specify) Morganza, Maryland 21. Signature of Funeral Service License 22. Name and Address of Facility Mattingley-Gardiner Funeral Home P.O. Box 270 Leonardtown, MD 20 Leonardtown, MD 20650 23a. Part1. Inter the disease, or complications that caused to shock, or heart failure. List only one cruse on each lin-1. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** WK /Medical ue to (or as a consequence of): Examiner INOBAC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner law requires that the death certificate be executed burial-trans TRIA BRIL Due to (or as a consequence physician Physician/Medical the as IF FEMALE: for use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1☐ Yes 2☑ No Month Day Year Yes 3 No 9 ☐ Unknown 4☐Pregnant at time of death 5 ☐ Other (specify) led by the a detached f 9☐Unknown signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗌 Yes 2**X**No 3 ☐ Probably 4 ☐ Unknown page 2 should 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has certificate 1□ Yes Physician: 25. Was case referred to medical examiner? director Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Date of Injury (Month, Day Year) 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To this funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation 1 Natural 2 Accident Injury 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 🕊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

P.O. Box 68760, Vital Records,

Hospital or Attending To the Hospium ... within 24 hours after death.

To the Funeral Director: A'

> State Registrar

Date filed (Month, Day, Year) OCT 0 9 2007

e0198

(Check only one) 29b. Signa

and title of certifier

32. Registrar's Signature

30. Name and address of person who completed cause of death (Herri 23a) (Tyr

Print)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date sigred (Menth, Day, Year)

Sq. Wahdorf, m.D. 20603

State Registrar

DHMH 17 Rev 1/2001

DETENSE

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year,

OCT 0 1 2007

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32. Registrar's Signature

Examiner The law requires that the death certificate be executed physician and s the burial-tran Division or Vital Records, P.O. Box 68760. attending pl ed by the a the Hospital or Attending Physician: director.

the

Funeral

Director

ral", or Items 23a or 28a-f show Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at

Physician

/Medical

Baltimore, Maryland 21215-0036

27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 5 15 - 1-5/1 wer 28c. Injury at Work? Injury 1 Natural 5 Pending investigation Jep 1 ☐ Yes 2 No 22 2007 1505 2 Accident wound 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Flural Floute Number City or Town, State) 76 30 Carroll Hrv 4 Homicide Hogpit ILonafork, mo 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) M.D 23/ D59121 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7600 CARROLL PARK MD 20912 I. MAL IK AVENUE TAKOMA M.D. 31. Date filed (Month, Day, Year) 32. Registrar's Signature OCT 0 3 2007

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** Month Mary Estelle Johnson October 6, 2007 2:55 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner St. Mary's Nursing Center Leonardtown St. Mary's 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** 1 M 2**XX**F 215-56-9839 84 Director Feb 7. 1923 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. If Item 27 is marked other than "natural", or items 23a or 28a-f show 10a State 10c. City, Town or Location 10b. County 10d. Inside City Limits ? is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Eximiner must be notified at 1 ☐ Yes 2 1 No Director Mary land St. Marv's Hollwood 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 43355 Johnson Road 20636 USA Funeral 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: þ White 3 ₩ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 8 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 James Warren Guy Lucy Estelle Long 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2. Department of Health a Important: If Item 27 is any injury or other trau Phyllis Mattingly / Daughter 43360 Johnson Road, Hollywood, MD 20636 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 □ Cremation 3 □ Removal from State Oct. 10,2007 4 ☐ Donation 5 ☐ Other (Specify) Charles Memorial Gardens Leonardtown, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Mattingley-Gardiner Funeral Home, P.A. Truchael P.O. Box 270, Leonardtown, MD 20650 e, or compleatives that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only the cause on each line. 23a. Part1. Enter the dise shock, or heart failur Immediate Cause (Final disease or condition resulting in death) **Physician** mence /Medical Due to (or as a consequ Examiner Sequentially list conditions, if a cause. Enter Underlying Cause (Disease or injury ner The law requires that the death certificate be executed attending physician and for use as the burial-transit Exam that initiated events resulting in death) Last Due to (or as a consequence of) P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ➡ No Month 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a s been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an cate has l page 2 s autopsy performed? Yes 2 No this certificate 1□ Yes 25. Was case referred to medical examiner? director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: P 1 Yes 2∰ No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t Medical Certification: 5 Pending investigation Hospital or Attending 1 A Natural Injury To the Hospital or Attendia within 24 hours after death.

To the Funeral Director: A completely filled in by the fu death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c, License number 29d. Date signed (Month, Day, Year) cause of death (Item 23a) (Type, Print) 30. Name and address of person who complete James P. Jarboe, M.D. Notch Road Hollywood, MD 20636 24035 Three 32. Registrar's Signature State Registrar

Director

Be Completed by Funeral

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Examiner

Physician/Medical

Certification: To Be Completed by

Medical

Physician /Medical

Examiner

Please Ty	pe or Print in I	ી 3lack ln∉	delible Ink	. Ensure A	Il Copies A	re Legible.	
For	State of Marylar	id / Depa	artment of H	Health and M		_	
1 State Registrar 1. Decedent's Name (First, Middle, Last)		Cei	rtificate of	Death	Reg	. No. 200	7 33355
Betty Jane Joh:	nson				Month OCT. 06	Day 2007	8:16 A M
4a. Facility Name (If not institution, give stre Ruxton Health o	eetand number) f Denton		4b. City, Town, o	r Location of Death		4c. County of Dea	
5. Social Security Number 6. Sex 1 1 N	7. Age (In yrs.	(ast birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y	ear) C	rthplace (State or Foreign ountry)
Usual Residence of Decedent					Dec. 5,	1916 Mi	nnésota
MD County Carolin		y, Town or Lo	eston				10d. Inside City Limits 1 ☐ Yes 2 🛣 No
10e. Street and Number 23350 Grove Roa	d		10f. Zip Code	21655	10g	. Citizen of What C United	
11. Marital Status 1 Never Married 2 Married 3 ☑ Widowed 4 Divorced	Was Decedent Ever in U Armed Forces? 1 □ Yes 2 1 No If Yes, Give Year or Dates:	'	Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 ☐XNo	lispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Whi Specify:	
15. Decedent's Educat (Specify only highest grade of Elementary/Secondary (0-12)	ion ompleted) College (1-4or 5+)	(Give	DO NOT use retire	during most of work d)	ing T1	b. Kind of Business Cansporta	tion of
17. Father's Name (<i>First, Middle, Last</i>)		Care	Provid	er for H	Elderly e (First, Middle, Ma	Patients	
Waitman George	Dolby				ice Agne	/	v
19a. Informant's Name/Relationship (Type	•	19b. Mailir	ng Address (Street		ral Route Number, C		
Noel J. Johnson					ton, MD 2		
20a. Method of Disposition 1	noval from State	cemetery, cier oomery	osition (Name of matory or other pla Cemetery	^{ce)} 10/09	9/07 Sn	c. Location - City o	. Maryland
21. Signature of Funeral Service Licensee	skur	22	2. Name and Addre 16 N. Mai	ess of Facility Fra .n St., Fe	amptom Fur ederalsbur	neral Homog, MD 21	e. ^{P.A.}
23a. Part1. Enter the disease, or complica shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last d	Due to (or as a consection of the consection)	D Dia juence of):					Approximate Interval Between Onset and Death 7 2—WCLL
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	If yes, outcome pf pregn. 1 Live birth 2 Fete 4 Pregnant at time of c	aldeath 3□	⊒Ectopic pregnanc □ Other <i>(specify)</i> _	у		23d. Date of de Month	elivery Day Year
Part II. Other significant conditions contri	*	~	nderlying cause giv	ven in Part I.			to the cause of death?
Uvra	^		,)	. `	1 ☐ Yes	2 ∏ √No 3 □ F	Probably 4 □Unknown
	menha (Alzho	umer's	type)	24a. Was an autopsy performe 1∐ Yes 2∑	/ prior to	
25. Was case referred to medical examiner?	pital:		Oth		h (Check only one)		
27. Manna of Death	28a. Date of Injury	ER/Outpatien 28b. Time of	IL 3 DOA	4 Nursing Ho	ome 5 Residence 28d. Describe how		ecify)
1 12 Natural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	(Month, Day Year) 28e. Place of injury - At h	Injury ome, farm, str	M 1□	rk? Yes 2 □ No	28f. Location (Street	et and Number or F	Rural Route Number,
29a. Certifier ↑ Certifying Physic	ian: To the best of my kno	owiedge, deatl	h occurred at the ti	me, date and place,	City or Town, S	se(s) and manner a	as stated.
one)	r: On the basis of examina and manner stated.	auon ang/or in					
29b. Signature and title of certifier	(MI)			616 88		Date signed (Mon	oth, Day, Year)
30. Name and address of person who comp	nleted cause of death (Iter	$\hat{D}_{\mathcal{O}}$	Print) Dni	ic the	ster Ms	21619	

State Registrar 31. Date filed (Month, Day, Year) OCT 1 1 2007



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			for State Registrar	State of Marylai			it of Heali te of Dea			2	007	333	56
	~**		Registrar 1. Decedent's Name (First, Middle, Last)		, ,	Jerunca	e or Dea	11/1	2. Date of Dea	eg. No L	,01	3. Time of D	
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	/Medic Examin		4a. Facility Name (If not institution, give s	treet and number)		4b. City	Town, or Local	tion of Death	JCP11	1	ty of Death	1.10	
	3 %. 30	ş	Deer'S HEAD HOS	Spital Cen	ter	_	SAL	Sburc	1		NiCo	MICO	
	Funeral		5. Social Security Number 6. Sex 1	7. Age (In yrs		nday) If Under		nder 24 Hrs. urs Min.	8. Date of Birth (Month, Day	, Year)		ice (State or F y)	
- ^	Director		Usual Residence of Decedent	54		13.			11/19/1	1952	North	Carol	ina
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	or ther		1 ☐ Never Married 2 X Married	12. Was Decedent Ever in the Armed Forces? 1 ☐ Yes 2 ☐ No lif Yes, Give			dent of Hispani cify Cuban, Me		Rican, etc.)		lack, White, e		
0030	irel',	d by	3 Widowed 4 Divorced	Year or Dates:		1 Tes	2XNo Spe	эспу:		Spec	ify: W	nite	
ה ה	within 72 flours affections. then "naturel", or ite	Completed	15. Decedent's Educ (Specify only highest grade		16a. [Decedent's Usu 'Give kind of wi life DO NOT i	al Occupation ork done during ise retired)	most of working	g	16b. Kind of	Business/Indu	istry	
7 7	o med withing all Hygiene. other then '	mo	Elementary/Secondary (0-12)	College (1-4or 5+) 4	1	alegal	30 /81/184/			law			
D	tal Hyg	BeC	17. Father's Name (First, Middle, Last)		, <u>.</u>				(First, Middle,		ame)		
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Mar	s I and 2 should be lied within 12 hours after death with the waryan Health and Kental Hygiene. I Health and Kental Hygiene. I the AT I is marked other then "nature!", or items 23s or 28s-f show other traumatic event, the Modical Examinar must be notified at		19a. Informant's Name/Relationship (Ty) Chris P. Dattalo/h	oe, Print) usban d	19b.	Mailing Addres	s (Street and No shire D	umber or Rural	Route Number	MD 2	n, State, Zip (1801	Code)	
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OF .			1 ☐ Burial 2 ☑ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)			, crematory`or ury Crei		9/27			oury, M		
Saltimo	2 5 5 6		21. Signature of Funeral Service Ligense			-	nd Address of F Way Fun						
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			23a. Part1. Enter the disease, or compli- shock, or heart failure. List only on	cations that caused the dea e cause on each line.	th. Do no	ot enter the mo	de of dying, suc	ch as cardiac or	respiratory arr	est,		Approximate Interval Betwe	
	hysician		Immediate Cause (Final disease or condition	Congesti	ve/	PAR	t + A	ilure			17	Onset and De	17/5
	/Medical Examiner		resulting in death)	out to (o) as a conse	quence of	0 009	1					1.101	26
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7	d d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	END S	TAG	e Re	NAL C	Vise	ASe			UPA	R
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5	this certific	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	ospital:] ER/Out	patient 3□ D	Othor		Check only or		Other (Case)		
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	or Author d	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At I building, etc. (Spec	nome, fari ify)	m, street, factor	y, office	2	8f. Location (S. City or Town	treet and Nut n. State)	nber or Rural	Route Numbe	er,
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	within 2 To the	ž	29b. Signature and title of certifier			29	c. License num		_	-	ned (Month, D	ay, Year)	
1	n.		I will a boy	~v ~			D00 3	2150	2//	3-27-	57		
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	Sta	ito:	31. Date filed (Month, Day, Year)	32. Segistrar's Sign	elcs lature	HEHO!	105/17/A	(GVE)	CITUDO	(all))HISDUI	47111)	× 1800
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Registrar

31. Date filed (Month, Day, Year) OCT 0 1 2007

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32. Registrar's Signature

DHMH 17 Rev 1/2001

State

30, Name and address of person who completed cause of death (Item 23a) (Type, Print)
SHALL B SHAMIM; WASHINGTON ADVENTIS 7 HOSP., TAKOMAPARK,

D-59284

Spring

10c. City, Town or Location

Silver

7. Age (In yrs. last birthday,

92

Certificate of Death

Spring

4b. City, Town, or Location of Death

If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min.

Silver Spring

Reg. No. 2007

2007

Montgomery

4c. County of Death

28

Date of Death
 Month

SEPT

8. Date of Birth (Month, Day, Dec

33358

3:05 PM

Birthplace (State or Foreign Country)

NC

20011

10d. Inside City Limits

1 ☐ Yes 🍇 ☐ No

Physician

/Medical

Examiner

Funeral

Director

1. Decedent's Name (First, Middle, Last)

LOGUE

6. Sex

1 ☐ M 2 🔀 F

4a. Facility Name (If not institution, give street and number)

Arden Courts of Silver

HELEN

5. Social Security Number

10a. State

5

MD

229-14-9318

Usual Residence of Decedent

T	Montgoi	пету						
al Direct	10e. Street and Number 3940 Rickove	er Rđ.		10f. Zip Code 2090	02	100	g. Citizen of What Co USA	
y runeral	11. Marital Status 1 □ Never Married 2th Married	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes ŽŪ No If Yes, Give	J.S.	13. Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 ☑ No	lispanic Origin? (\$ an, Mexican, Puer Specify:	Specify Yes or No- to Rican, etc.)	14. Race - Ame Black, Whi	
ied Dy	3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Ed	Year or Dates:	16a. [Donadant's Heual Occur	ation	16	6b. Kind of Business	
paladillon ad	(Specify only highest gra Elementary/Secondary (0-12)	College (1-4or 5+) 4yrs		Give kind of work done life. DO NOT use retire OUSEWIFE	during most of wo d)	rking	None	
	17. Father's Name (First, Middle, Last William T. Ha					me (First, Middle, Ma na Lewis		
	19a. Informant's Name/Relationship (Janice Hill/Da	Type Print) ughter	392	Mailing Address (Street	and Number or R	ural Route Number, (Silver	cing Joya State,	Zio Code) 2002
	20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specia	Removal from State	cemetery	Disposition (Name of , crematory or other pla			Oc. Location - City or	
	21. Signatore of Funeral Service Licer			What and Address 4804 Ge	i		Washingt	2001
	23a. Part1. Enter the disc se, or comshock, or heart failure. List only Immediate Cause (Final disease or condition	one cause on each line.		ot enter the mode of dyings Disease	ng, such as cardia	c or respiratory arres	t,	Approximate Interval Between Onset and Death
	resulting in death)	Due to (or as a consec	quence of	n):				
Fydillici	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consec		,				
		Due to (or as a consect	quence of	···				
30000	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 XNo 9 □ Unknown	23c. If yes, outcome pf pregn 1 ☐ Live birth 2 ☐ Fet 4 ☐ Pregnant at time of 9 ☐ Unknown	al death	3 □Ectopic pregnanc 5 □ Other (specify) _	у		23d. Date of de Month	blivery Day Year
completed by hillysiciallymedical	Part II. Other significant conditions of Type II Dial			the underlying cause giv	ven in Part I.	23e. Did toba 1 ☐ Yes		o the cause of death? 'robably 4 □Unknov
out bick						24a. Was an autopsy perform 1 Yes 2	prior to	utopsy findings availab completion of cause o
	25. Was case referred to medical examiner?				26. Place of De	ath (Check only one)	1	
2	1 Yes 2000	Hospital: 1 ☐ Inpatient 2 ☐] ER/Outp	oatient 3 DOA Oth	ier: 4 🖾 Nursing	Home 5 ☐ Residen	ce 6 □Other (Spe	ecify)
	27. Manner of Death 1 ☑️Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Ti Inj	jury Woi	ryat rk? Yes 2 ∐ No	28d. Describe how	injury occurred	
Medical Celtification.	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined			m, street, factory, office		28f. Location (Stre City or Town,	et and Number or R State)	lural Route Number,
anical	29a. Certifier (Check only one) 1 Certifying Pt 2 Medical Example 1 Medical Example	nysician: To the best of my kn miner: On the basis of examin and manner stated.	owledge, ation and	death occurred at the ti l/or investigation, in my	me, date and place opinion, death occ	e, and due to the causurred at the time, dat	ise(s) and manner a re and place, and du	s stated. le to the cause(s)
MIN	29b. Signature and title of certifier,	M	>	29c. Licens			d. Date signed (Mon	
į	ame and address of person who	completed cause of death (Ite	m 23a) (T	D4 Type, Print) Laurel	32.37		-10per	2001
3	TAUL ARMSTRON	19, 4.0. 14	401	Laurel	Park DR	- 102 A	arrel, M	0 20707

32. Registrar's Sign

31. Date filed (Month, Day, OCT 0 3 2007

State Registrar DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1- State Amend #106&c& State of Maryland / Department of Health and Mental Hygiene
Registrar Amend #10e&f Per Inf G873 11/05/107/2014 of Death
Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Day 12:20 A^M Winifred Edith Lamb October 0 10, 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Leonardtown

Leonardtown

Leonardtown

If Under 24 Hrs. St. Mary's Nursing Center St. Mary's 8. Date of Birth (Month, Day, Year) 5. Social Security Number . Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1 ☐ M 2 🛛 F 212-82-9520 Director 84 11/28/1922 Canada Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10d. Inside City Limits r 28a-f show notified at show Director 1 ☐ Yes 2 X No Maryland Hartford Balto Belcamo Sparks 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or Items 23a or 1641 Cold Bottom RD United States 4307 Marigold Lane Funeral 21017 21152 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify: \$ Specify: 3 Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry r than Elementary/Secondary (0-12) College (1-4or 5+) th and Mental Hygier
7 is marked other the Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be မှ Wilfred Llewellyn Cullis Catherine Edith Liddy 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 23615 Town Creek Drive, Lexington Park, MD 20 ace of Disposition (Name of Date 20c. Location - City or Town, State item 27 Gwyneth Hein/Daughter 20653 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition ₽ Department of Important; If it any Injury or o 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Brinsfield-Echols Cre10/11/2007 | Charlotte Hall, MD 22. Name and Address of Facility Brinsfield Funeral Home, P.A. M00052 22955 Hollywood Road, Leonardtown, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Fai Physician MACIN disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** emen Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed MOONIC attending physician and for use as the burial-tran Due to (or as a consequence of) P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the a d be detached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 1 | Yes 2 | No 3 | Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an this certificate has al director, page 2 autopsy perform or Attending Physician: 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 5 Pesidence 6 Other (Specify) 1 ☐ Yes 2 No 27. Manner of Death

1 Natural

2 Accident 28a. Date of Injury 28b Time of 28d. Describe how injury occurred After (Month, Day Year) 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No To the Funeral Director: completely filled in by the 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 24 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 47066 10.10.0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 1/2001

State

Avani D. Shah, M.D.

OCT 1 1 2007

31. Date filed (Month, Day, Year)

22650 Cedar Lane Court, Leonardtown, Maryland 20650

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** SEPTEMBER 28, 2007 CLINTON 6:48 P EARL LISTER /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner FREDERICK FREDERICK MEMORIAL HOSPITAL FREDERICK If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday 9. Birthplace (State or Foreign **Funeral** Months Days Hours 1 ₩ 2 □ F 1929 577-42-4010 78 Pennsylvania March 6, Director Usual Residence of Decedent 10b. County 10c. City. Town or Location 10d. Inside City Limits show ir than "natural", or items 23a or 28a-f shov the Medical Examiner must be notified at 1√Yes 2□No Directo Maryland Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 109 Charleston Lane 21702 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 1 Yes 2 □ No If Yes, Give Workson Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status Black, White, etc. within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No Baltimore, Maryland 21215-0036 Specify. ģ Specify: 3 Widowed 4 Divorced Year or Dates: Korean White Completed 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than any injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) Manager Wash. Gas & Light 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mary E. Sisler Clinton I. Lister ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 102 Charleston Lane, Frederick, Maryland 21702 Jack Mason / Friend 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Smithsburg Crematory 10/1/07 Smithsburg, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service L ROBERT E. DAILEY & SON FUNERAL HOMES, P.A. 1201 NORTH MARKET ST., FREDERICK, MD 21701 the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or comshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) failure **Physician** /Medical Due to (or as a consequence of) Examiner MMON Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Die to or as a consequence of Examiner the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4□Pregnant at time of death 5 Other (specify) signed by the a d be detached f 1 ☐ Yes 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 cate has been signification of the category and category. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an was autopsy performed? Yes 2 No 1□ Yes Physician: funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No Certification: To 1

Inpatient 2 ER/Outpatient 3□ DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 1 Natural 5 Pending investigation Injury death. 1 ☐ Yes 2 ☐ No 2 Accident Director: filled in by the 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Hospital or A 24 hours after 4 Homicide To the Hospital within 24 hours a To the Funeral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated.

Myung Nam, 31. Date filed (Mo (TO), () ar) State Registrar

29b. Signature and title of certifier

MD

egistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2007

400 West Seventh Street, Frederick, Maryland 21701

0035106

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day 2007 Year October 8, **Physician** Wilson McElhoe 2:23 A Chester /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Shady Grove Hospital Rockville Montgomery 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Days Min. Months Hours May 9, 1923 1**XX**M 2□ F 84 Pennsylvania Director 210-12-1108 Usual Residence of Decedent or 28a-f show e notified at 10c. City. Town or Location 10d. Inside City Limits 10a State 10b. County 1 ☐ Yes 2 Totalo Director Maryland Montgomery Bethesda 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code l or 5101 River Road 20816 USA ral", or Items 23a Examiner must b death by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 Never Married Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify. Specify: White 3 Widowed 4 Divorced 'natural", Year or Dates: Completed 16a. Decedent's Usual Occupation the Medical 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Military Government permit. Pages 1 and 2 should be filed w Department of Health and Mental Hygie Important: If Item 27 Is marked other than any Injury or other traumatic event, the once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Chester McElhoe 2 Susan Henry 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lucille Grove Mcelhoe - Wife 922 S. Marshall Street, Front Royal, Virginia 22630 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ emation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Augusta Cremation Service 10/10/07 Waynesboro, Virginia 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 1200 N. Shenandoah Ave. diana Turner-Robertshaw F.H. Front Royal, Virginia 22630 10 WACG 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Myocardial Infarction 1 Week disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed the burial-tran and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknows signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Aortic Stenosis 1 Tyes 2XXVo 3 ☐ Probably 4 ☐ Unknown Be Completed Hyper Cholesterolemia 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 s 1 Yes XXNo Hospital or Attending Physician: director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☐ X X Certification: To 1 XX patient 2 ER/Outpatient 3 DOA funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation 2 Accident 24 hours after death Funeral Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Xifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical completely (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) within 24 and manner stated. the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D47722 10 /08/2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5 15825 Shady Grove Road Suite 60 Rockville, Maryland 20878 32 Registrar's Signature 31. Date filed (Month State 2007

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** MODERACKI 8 2007 6:00 A Oct. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** Carroll 1907 Killarney Dr. Westminster If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 🕇 F 81 May 9, 1926 Delaware Director 221-14-7452 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ant: If Item 27 is marked other than "natural", or Items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notifiled at 10c. City, Town or Location 10b. County 10d. Inside City Limits 10a. State MD Carroll Westminster 1 ☐Yes 2 No Funeral Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21157 USA 1907 Killarney Dr. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ★ No Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: White Completed by 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Clerical Department Store 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Anna Marie (Mahler) Sharp Howard M. Sharp ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1907 Killarney Dr., Westminster, MD Jeffrey A. Moderacki Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ABurial 2 ☐ Cremation 3 ☐Removal from State Department o Important: If any Injury or once, Rocky Gap Veterans Cem Oct 12 07 | Flintstone MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hafer Funeral Service 21. Signature of Funeral Service Licenses orn 1302 National Hwy., LaVale, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure? List only one cause on each life. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequent of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or nijury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4□Pregnant at time of death 5 ☐ Other (specify) been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 ☐Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No 24a. Was an autopsy performed res 2 certificate 1□ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA ို 27. Mann f Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural Injury 5 ☐ Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director; p

Certification: Medical

29a. Certifie (Check one) 29b. Signatu nd title of certifier

1 🗂 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

completed cause of death (Item 23a) (Type, Print) 555 South Center St. Westminster MD 21157

7 2007

31. Date filed (Month, Day, Year)

32 Registrar's Signature

3

Registrar

State

DHMH 17 Rev 1/2001

State Registrar

Mangoaela

32. Registrar's Signal

			For State Registrar	State of Marylar		artment o rtificate			lental Hy	giene Reg. N2 0 0	7 33364
ľ	Physicia		1. Decedent's Name (First, Middle, Last) CASEY BERNARD I	MARSHALL SI	R.				2. Date of De Month SEPTEM	ath IBER 23	3. Time of Death Year 2007 5:59 P M
	/Medic Examin		4a. Facility Name (If not institution, give sa	reet and number)				tion of Death		4c. County of	of Death
	Š., .		Suburban Hospital 5. Social Security Number 6. Sex	7. Age (In yrs	last hirthday)	If Under 1 \	ethes	da nder 24 Hrs.	8. Date of Bir	Montg	
	Funeral Director			M 2□F 42	Yrs.		ays Ho	urs Min	(Month, Da May 28	v. Year)	9. Birthplace (State or Foreign Country) AR
	land bw t		Usual Residence of Decedent 10a. State 10b. County	10c. C	ity, Town or Lo	cation					10d. Inside City Limits
	e Mary a-f sho ified a	ctor	AR Jefferson	Pi	ne Bluf	f					1⊠Yes 2□No
	with the a or 28 be not	Funeral Director	10e. Street and Number			10f. Zip Co			ŀ	10g. Citizen of W	hat Country?
	ms 23	neral	1302 Ridgway Road 11. Marital Status	2. Was Decedent Ever in U	J.S. 13.		1603 t of Hispani	c Origin? (Spe	ecity Yes or No Rican, etc.)	USA 14. Race	- American Indian,
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	by Fur	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		fYes, specify 1 □ Yes 21X		exican, Puerto ecify:	Rican, etc.)	Black Specify:	, White, etc.
9	'2 hour natural ical Ex	ted k	15. Decedent's Educ	ation	16a. Dece	dent's Usual C	ocupation			16b. Kind of Bus	Black siness/Industry
21215-0036	vithin 7 sne. than "r ie Med	To Be Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)			etired)	most of worki	ng	None	
	filed v Hygie other t ent, th	e Co	17. Father's Name (First, Middle, Last)	2 yrs.	DISA	bled	18. N	Nother's Name	(First, Middle	, Maiden Surname	······································
ylan	Menta Menta arked atlc ev	To B	Charlie Marshall,	Jr.			M	orsa F	luker		
Baltimore, Maryland	id 2 shoth and the and		19a. Informant's Name/Relationship (<i>Typ</i> Nadine Marshall/W			ng Address <i>(S</i> : Ridgw			al Route Numb ine Blu	er, City or Town, S aff , AR	State, Zip Code) 71603
ore,	es 1 and 2 and 4 filtem 27 is		20a. Method of Disposition 1 ⊠ Burial 2 □ Cremation 3 □ Re	ì	Place of Dispo cemetery, crei	sition (Name	of .		Date	20c. Location - 0	City or Town, State
ţ <u>i</u>	t. Pag rtment rtant: I		4 ☐ Donation 5 ☐ Other (Specify)	St	. Mark		-	10-2-		Sherrill	L, AR
Ba	permi Depar Impor any Ir		21. Signature of Funeral Service License	hall	<u> </u>	<u>217 9t</u>	h Str	eet, N		ington,	DC 20011
			23a. Party. Enter the disease, or complic shock, or heart failure. List only one Immediate Cause (Final	cause on each line.	*	4		ch as cardiac o	or respiratory a	rrest,	Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	Due to (or as a conse	quence of):	rrhyt			,		hours
b	Examiner	<u></u>	Sequentially list conditions, b	Due to (or as a consec	fustiona	al in	10	verloa	d		years
7	uted d ansit	Examiner	Squentially het our difference if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Sick	le Cell	disci	rse				years de cades
60,	be exec cian an ourial-tr	al Exa	that initiated events c. resulting in death) Last	Due to (or as a consec	quence of):						
68760,	fficate t physic sthe t	edical	d.								
30X	ath cert	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	c. If yes, outcome pf pregn 1 Live birth 2 Fet]Ectopic pregi	nancy			23d. Date Mon	of delivery th Day Year
0	the dea y the at ched fo	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at time of 9□Unknown	death 5□	Other (speci	fy)			IVIOII	th Day Year
S, D	w requires that the death certificate be executed been signed by the attending physician and should be detached for use as the bunal-transit	by Ph	Part II. Other significant conditions cont	ributing to death but not res	sulting in the u	nderlying caus	e given in F	Part I.	23e. Did t	1/	bute to the cause of death?
örd	requir				<u></u>				10		3 ☐ Probably 4 ☐ Unknown
Rec	The law te has t age 2 s	Completed							24a. Was auto perfo	psy pr prmed? de	/ere autopsy findings available ior to completion of cause of eath? □ Yes 2 No
ta	ding Physician: The lav n. After this certificate has funeral director, page 2	Be C	25. Was case referred to medical examiner?				26. F	Place of Death	1 X Yes (Check only o		∐Yes 2/ANo
or/	Physic this cral dire	2	1 Yes 2 No	spital: 1 ☐ Inpatient 2 2 28a. Date of Injury	ER/Outpatien					dence 6 Othe	
lon	ath. r: After	ation	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury	M 200.	Injury at Work? 1 □ Yes		Lou. Describe	now injury occurre	ŭ
Division or Vital Records, P.O. Box	or Attendate death Director:	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - At h building, etc. (Speci	ome, farm, str	eet, factory, of	ffice	2	28f. Location (City or To	Street and Numbe wn, State)	r or Rural Route Number,
	Hosp 4 hou Fune rely fil	ical Ce	(Check only 2 Medical Examin	cian: To the best of my kn	owledge, death	occurred at t	he time, da my opinion	ite and place,	and due to the	cause(s) and mar date and place, a	nner as stated. nd due to the cause(s)
	To the I	Medical	one) 29b. Signature and title of certifier	and manner stated.			cense num				(Month, Day, Year)
			► Watter M	the mo		D	05710)6			24, 2007
2	(3)		30. Name and address of person who con MATTHEW HSIEH				DTWE	DET	IECD 4	MADVIA	ND 20002
j	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Sign	ature	IER D.	XIVE,	, DEIH	LESUA,	TIAKILA	ND 20892
	Registr	ar .	OCT 0 3 2007		Todated						

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erry Neil McKinne	1- For State	Department of Certificate of		lental Hygiene	21	007 3336							
Physician	Registrar 1. Decedent's Name (First, Middle,Last)		2041.7	2. Date of	Death .	3. Time of Death							
Medical Examine		McKinn	-		er 7, 2007	1747 hrs							
	Facility Name (if not institution, give street and number) St. Mary's Hospital		b. City, Town, or Local Leonardtown	tion of Death	4c. County of St. Mary's								
Funeral		(In yrs. last birthday)		Under 24Hrs. 8. Date		Birthplace (State or Foreign							
Director	579-58-9607 1X M 2 F	59 Yrs.	Months Days H	fours Min. 10/2	25/1947	Country) Mississippi							
>	Usual Residence of Decedent 10a. State 10b. County 1	0c. City, Town or Locati	- 			Table Incide Ottoblish							
1 low any	Maryland St Mary's	Mechanic				10d. Inside City Limits 1 Yes 2 No							
the Maryland a or 28a-f show tified at once.	10e. Street and Number		10f. Zip Code		10g. Citizen of What								
the M sa or 2 biffed			2065	9	U S	A							
or items 23a or 28a-f sho	11. Marital Status 1 Never Married 2 Married Armed Forces?			o Origin? (Specify Yes o		American Indian, Black, etc.							
ter dea	1 3 Widowed 4 Divorced III Yes, Give Year	No 1	Yes 2 X No spe	ecify:	Specify:	White							
15-0036 filed within 72 hours after of litygiene. ed other than "natural", of the Medical Examiner in a Commilated by F	l or Dates:	leted) 16a. Deceden	's Usual Occupation (C	Give kind of work done	16b. Kind of Busin								
5-0036 ed within 72 hour lygiene. the Medical Exam	Elementary/Secondary (0-12) College (1-4 or 5+	.)	ost of working life. DO I	NOT use retired)									
-003 I within giene. Ther the	10 17. Father's Name (First, Middle, Last)	Pa	inter I18.Mc	other's Name (First, Mid	_	roft Raceway							
21215-0036 uld be filed within 7 Mental Hygiene. marked other than e event, the Medica			L	oretta	G.	Lake							
	19a. Informant's Name/Relationship (Type, Print)	1.0				State, Zip Code) 20659							
, MD and 2 sho ealth and em 27 is	Margaret A. McKinney 20a. Method of Disposition		Morganza tion (Name of cemeter		, Mechanics	ville, MD Dity or Town, State							
Baltimore, permit. Pages I ar Department of Hee Important: If ite Injury or other tr	1 Burial 2XX Cremation 3 Removal from State	e crematory or oth	er place)										
altin nit. Pe artmer oortan ny or	4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee	Brinsfiel		10/13/07		te Hall, MD							
Balt permit. Departi Impor- injury	Mat Calult MOO	817 30	insrield-E 195 Three	Notch Rd.,	Charlotte	A Hall, MD 20622							
Physician /Medical	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximately a such as cardiac or respiratory arrest, shock, or heart failure. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.												
xaminer	Immediate Cause (Final disease or condition resulting in death) A Hypertensive Ath Due to (or as a consequence)		ovascular Diseas	e		Death							
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). Box 6876C the death certificate by the attending physicited for use as the br	1 Yes 2 No 9 Unknown g Unknown					·							
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ords, P.C w requires that is been signed to should be detail	Chionic edianonam					ere autopsy findings available							
Records, The law requires are has been signage 2 should be completed		 			performed? de:	or to completion of cause of ath?							
Division of Vital Records, tale or Attending Physician: The law requirers after death. al Director: After this certificate has been sited in by the funeral director, page 2 should be prification: To Re Completed	25. Was case referred to medical		26.Place of De	eath (Check only one)	Yes 2 No 1	Yes 2 No							
F Vital Physician: r this certifi al director,	Introductions	2 V ER/Outpatient				Other:							
ding Ph	27. Manner of Death 1 V Natural 5 Pending 28a. Date of Injury (Month, Day,Yea		njury 28c. Injury at N		cribe how injury occurred	i							
Sion Attencer death rector:	2 Accident Investigation 28e. Place of Inju	ry - At home, farm, stree			tion (Street and Number	or Rural Route Number, City							
Division ospital or Attending tours after death. Ineral Director: After filled in by the function:	3 Suicide 6 Could not be determined (Specify)			or To	wn, State)								
5 - S	cause(s) and manner a												
To the H within 24 To the Fi completed	one) 2 Medical Examiner: On the basis of examinand manner stated 29b. Signature and title of certifier	nation units of investigat	29c. License nun			(Month, Day, Year)							
	anes ?		O.C.M.E.		October 8, 2								
() a	30. Name and address of person who completed cause of dea			W									
10	Ana Rubio MD. Assistant Medical Examin		treet, Baltimore,	MD 21201									
Stat Registra	a north this	Signature	N .										
DHMH 17 Rev 1/2001 OCME 2006		ORIGINA		OCME									

State Registrar DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** rancis azziott 2007 /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Coastal Hospice at the Lake Salisbur WICOMICO If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year 10/24/1935 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 6. Sex Hours Months Min Days 1 ☑ M 2 ☐ F MD 216-34-5384 71 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2√ No Director MD Ocean Pines Worcester 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11431 Manklin Creek Rd. 21811 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Bace - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 □ Never Married 2 T Married 1 ☐ Yes 2 ▼No Specify: White Specify 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 11 Maintenance Soap Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Nicholas Mazziott Rosalie Tucciarella 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dianne M. Mazziott / wife 11431 Manklin Creek Rd., Ocean Pines, MD 21811 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Cape Henlopen Crem. 4 ☐ Donation 5 ☐ Other (Specify) 10/3/2007 Frankford, DE 21. Signature of Funeral Servin 22. Name and Address of Facility The Burbage Funeral Home 108 William St., Berlin, MD 21811 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final resulting in death) Due to (or as a consequer ce of) Sequentially list conditions, if any, leading to immediate cause. Enter uncertain Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9☐ Unknown 9 I Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 100 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 1 Impatient 2 ER/Outpatient 3 DOA P 27. Manner of Teath 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No

Examiner the death certificate be executed signed by the attending physician and be detached for use as the burial-tra P.O. Box 68760. The law requires that Division or Vital Records, has certificate To the Hospital or Attending Physician: this funeral

To the Funeral Director: After completely filled in by the funer. hours after

Funeral

Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
ant: If item 27 Is marked other than "natural", or Items 23a or 28a-f show Lry or other traumatic event, the Medical Examiner must be notified at

Important: If it any injury or o

Physician

/Medical

Baltimore, Maryland 21215-0036

2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide determined

nh

Medical

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

D26278

29b. Signature and title of certifie

29c. License number 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause

OBOX 1733 Salish, MO 21802 OLLA 31. Date filed (Month, Day, Year)

State Registrar

3 2007 0

within 24

BA 7

Minten, Hareld DOB 4113/16 TODIOSA Division or Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p

30

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year	
Part II. Other significant conditions Athlews	contributing to death but not resulting in the	underlying cause given in Part I.		o use contribute to the cause of death?	
			24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 No	
25. Was case referred to medical examiner?	Hagnital:		ath (Check only one)		
1 ☐ Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatie	nt 3 DOA Other: 4 Nursing I	Home 5 ☐ Residence	6 ☐Other (Specify)	
27. Manner of Death 1 Natural 5 ☐ Pending 2 ☐ Accident investigation		of 28c. Injury at Work? M 1 ☐ Yes 2 ☐ No	28d. Describe how injury occurred		
3 ☐ Suicide 6 ☐ Could not be determined		treet, factory, office	28f. Location (Street a City or Town, Sta	and Number or Rural Route Number, te)	
29a. Certifier (Check only one)	nysician: To the best of my knowledge, dea miner: On the basis of examination and/or i and manner stated.	th occurred at the time, date and place nvestigation, in my opinion, death occ	e, and due to the cause curred at the time, date a	(s) and manner as stated. nd place, and due to the cause(s)	
29b. Signature and title of certifier	1/ 1/	29c. License number	29d. D	eate signed (Month, Day, Year)	
> Maleew,	Rendutus	D003671	16 Oc	tober 1, 2007	
	completed cause of death (Item 23a) (Type and var, M.D. 6/1	Print) 21 Mortruse	Rd. Rock	tober 1, 2007 Kuille, Md.	
31. Date filed (Month, Day, Year) OCT 0 3	32. Registrar's Signature	bout	,		
	OF	RIGINAL			

State Registra Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland / Department of Health and No. 1 - State of Maryland / Department of Health and No. 24a per verb., g8/3.11/06/0/dhb	Mental Hy	giene Reg. No.	2007	33368
		9	1. Decedent's Name (First, Middle, Last)	2. Date of De		Year	3. Time of Death
	/sicia ledic	-	Stephen Mazcko, Sr.	Oct	Day 5	200	7 1350P ^M
	amin		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death		4c.	County of Dea	
			Chester River Hospital Center Chestertown			Kent	
Fune Direc	_		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 85 Yrs. Months Days Hours Min.	8. Date of Bir Nov 7	th 19, Year)	C C	thplace (State or Foreign ountry) nnsylvania
and	_	ŀ	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
Mary!	ed a	5	Maryland Queen Anne Barclay				1 □Yes 2 ☑ No
the 28a	notif	Je l	10e. Street and Number 10f. Zip Code		10a. Citi	zen of What C	ountry?
3a or	st pe	Funeral Director	206 Cosden Road 21607		US	SA	
death ms 2	Ë	ner	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Sp. Armed Farses)	pecify Yes or No		14. Race - Ame	
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show	Examine	þ	Armed Forces? 1 Never Married 2 Married 1 Yes, Give Year or Dates: Armed Forces? If Yes, specify Cuban, Mexican, Puèric 1 Yes, Give Year or Dates:	o Hican, etc.)		Black, Whi	White
5-0 72 hg	dica	Completed	15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of work	kina	16b. Kii	nd of Business	/Industry
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hould d Me	Hatic	유 .	19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Ru				Zin Code)
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Baltimore, permit. Pages 1 ar Department of Hea Important: If item	any inju		21. Signature of Puneral Service Licensee 22. Name and Address of Facility	fonhoi	n Eu	nomal	Home DA
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cords, P w requires that been signed before	DIN I		Itapor i pidomia	1 🗆 '	Yes 2[∏No 3∏P	robably 4 Unknown
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Vital Rec	dage	Completed		autoj perfo	psy ormed? 2 ₩No	death?	completion of cause of 2 □ No
Vital ilcian: T	Ctor,	Be	25. Was case referred to medical examiner?				
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dlng Phy After thi	nuera		27. Manner of Death 1. Def Atural 5 □ Pending (Month, Day Year) 28b. Time of Injury 28b. Time of Injury Work?	28d. Describe	how injur	y occurred	
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Division or Vital To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director, After this certified		Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occur and manner stated.	, and due to the rred at the time,	cause(s) date and	and manner a place, and du	s stated. e to the cause(s)
To the To the To the	LIOO	ž	29b. Signature and title of certified.	,	29d. Dat	e signed (Mgn	th, Day, Year)
			Vankename 058824	'	10	0/8/0	7
			30 Marme and address of person who completed cause of death (Item 23a) (Type, Print) 1 AUL DONAHE 119 C Main St / Galing	MDo	163	25	
	Stat		31. Date filed (Month, Day, Year) 32. Registrar's Signature	*		_	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 33369 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2007 Year Day **Physician** Emily Marguerite Montgomery 10:00 P M 8 October /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Caroline Nursing Home, Inc. Caroline Denton 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 □ F Months Hours Min. 215-16-3691 86 Director 1920 Maryland December 2. Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10h. County show r 28a-f show 10d. Inside City Limits 1 ☑ Yes 2 ☐ No Director Ridgely Caroline Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or Items 23a or the Medical Examiner must be United States of America 21660 302 Central Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status filed within 72 hours after 1 ☐ Yes 2 ½☐
If Yes, Give
Year or Dates: 1 ☐ Never Married 2 ☐ Married 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No þ Specify. 3 Widowed 4 Divorced Caucasian 'natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Food Production Company HS Grad Bookkeeper permit. Pages 1 and 2 should be file Department of Health and Mental Hy Imporant: If Item 27 is marked ofthe any Injury or other traumatic event, once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Emily Marguerite Beaumont ပ Francis Lynch 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3506 Edgefield Road, Greensboro, North Carolina Francis L. Montgomery Son 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Greensboro, Maryland Holy Cross Cemetery 10/13/2007 4 Donation 5 ☐ Other (Specify) 22. Name and Address of Facility, Moore Funeral Home, P.A. Signature Funeral 004 South Second Street, Denton, Maryland 21629 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician heimer years /Medical Due to (or as a consecutince of): Examiner Sequentially list conditions, if any, leading to immediate cause. Errier underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): physician a the burial-Physician/Medical IF FEMALE: yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy perform 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ို 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Medical Certification: 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural within 24 hours after death.

To the Funeral Director: A completely filled in by the fi efter death 2 Accident 1 Yes 2 No

P.O. Box 68760. Division or Vital Records,

> State Registrar

6 Could not be determined

M.D.

DCT 1 1 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3 ☐ Suicide

29a. Certifier (Check only one)

4 Homicide

29b. Signature and title of certifier

Zaki,

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1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

0047534

Denton, Maryland 21629

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Market Street,

Registrar's Signat

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland , 1 - State Registrar		artment of H <i>tificate of L</i>		lental Hyç ı	giene Reg. No. 20	07	33370
S.	Physici /Medio		1. Decedent's Name (First, Middle, Last) Thomasina McNeill				2. Date of Dea Month		Year	3. Time of Death
The second second	Examin Funeral Director		4a. Facility Name (If not institution, give street and number) Civista Hospital 5. Social Security Number 6. Sex 1 M 2 M F 40	t birthday) Yrs.	4b. City, Town, or LaP1a: If Under 1 Year Months Days		8. Date of Birtl (Month, Day	4c. County	of Death Cha 9. Birth	
	the Maryland 28a-f show notffled at	Director	Usual Residence of Decedent 10a. State 10b. County 10c. City, T MD Prince George's Wale 10e. Street and Number	own or Loo	cation			10g. Citizen of V		10d. Inside City Limits 1 √ Yes 2 □ No
036	urs after death witt al", or items 23a or Examiner must be	by Funeral	2466 Quaker Court 11. Marital Status 1 □ Never Married 2 Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 M No If Yes, Give Year or Dates:		20602 Was Decedent of Hi f Yes, specify Cuba	ispanic Origin? (Sp nn, Mexican, Puerto Specify:		U.S.	A. e - Americ ck, White,	can Indian,
Maryland 21215-0036	should be filed within 72 hours after death with the Maryland und Mental Hyglene. Ind Mental Hyglene. In marked other than "natural", or items 23a or 28a-f show umatic event, the Medical Examiner must be notified at	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12TH 17. Father's Name (First, Middle, Last)	(Give I life. E	lent's Usual Occupa kind of work done of DO NOT use retired Customer	furing most of work) Service		16b. Kind of Bu	e	dustry
rylanc		To Be	GEORGE BURWELL	10h Mailin	g Address (Street a	18. Mother's Name Shirley	Powe			Code
	1 and 2 a Health ar em 27 Is ther trau		Carlouis V. McNeill/Husband	2466		Court Wal			2060)2
altimore,	permit. Pages Department of I Important: If ite any Injury or of			rrect	natory or other plac Lion Ceme . Name and Addres	terý 10-1		Clinton	,Mar	y1and
Ba	Dept Impo	. 6	23a. Part1. Enter the disease, or complications that caused the death. [74	474 LANDO	VER ROAD	LANDOVE	ER, MD 2		
	Physician /Medical Examiner		shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) List only one cause on each line. List only one cause on each line. List only one cause on each line. List only one cause on each line. List only one cause on each line. List only one cause on each line. List only one cause on each line. List only one cause on each line. List only one cause on each line. List only one cause on each line. List only one cause on each line. List only one cause on each line. List only one cause on each line. List only one cause on each line. List only one cause on each line. List only one cause on each line. List only one cause on each line. List only one cause on each line.		ar the mode of dyin	g, such as caldiac	or respiratory an			Approximate Interval Between Onset and Death
68760,	ficate be executed physician and is the burial-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence or consequence) c. Due to (or as a consequence)							
O. Box	death certif e attending id for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal de 4 □ Pregnant at time of deati	eath 3	Ectopic pregnancy Other (specify)				te of delive	ery Day Year
1	law requires that the as been signed by th 2 should be detache	by	Part II. Other significant conditions contributing to death but not resultin	ig in the un	nderlying cause give	en in Part I.				he cause of death?
Vital Hecords,	The ate has page	Completed	DIABETES MELLITUS TYPE 2				24a. Was a autop perfor 1 Yes	med?	prior to co d <u>ea</u> th?	opsy findings available impletion of cause of
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ion or	≥ .º ⊅	-	To injection 2 (22)	Bb. Time of Injury	28c. Injury Work	4 🗆 Nursing Ho	me 5 LJ Resid 28d. Describe h			5)
27. Manner of Death 1									er or Rura	al Route Number,
	the Hospl iin 24 hou the Funer tpletely fill	Medical	29a. Certifier (Check only one) 1 ☆ Certifying Physician: To the best of my knowle 2 ├ Medical Examiner: On the basis of examination and manner stated.	dge, death and/or inv	vestigation, in my o	pinion, death occur	and due to the ored at the time,	cause(s) and madate and place,	anner as s and due t	itated. o the cause(s)
)	To To	2	29b. Signature and title of certifier	0	29c. License	number 0:5967		29d. Date signer	d (Month,	Day, Year)
R	7		30. Name and address of person who completed cause of death (Item 23 Gren M. Jacobs M.D. 1221 Merc	antil		Largo, Ma	ryland	20774		
	Sta Registr		31. Dese filed (Morth, Day, Year) OCT Q 1 2007 Security 132. Registrar's Signature	este						

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygien 2007 33371 For State Registrar Certificate of Death Rag. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year September 20,2007 **Physician** Ear1 Miller 10:20 p м /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Blue Point Nursing Home Baltimore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 12/09/1922 7. Age (In yrs. last birthday) 9. Birtholace (State or Foreign **Funeral** Months 1**™** M 2□ F Days Hours Washington, DC 84 Vrs 577-28-1702 Director Usual Residence of Decedent death with the Maryland 10a. State 10c. City. Town or Location 10d Inside City Limits 10b. County 7 is marked other than "natural", or items 23a or 28e-f show treumatic event, the Modical Exeminer must be notified at 1X Yes 2 □ No DC Director Washington, DC 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2307 I St. NW 20007 USA Funeral 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item any injury or other treumatic event, the Medical Examinat once. Armed Forces Yes 2 No 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 Tyes 2K No If Yes, Give Year or Dates: Specify: Specify: Black þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Messenger Government 17. Father's Name (First. Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Carleton Miller ٥ Rosa Earle 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, Thelma Marshall/ Sister 4906 Arkansas Ave. NW, Washington, DC 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Harmony Memorial Park 09/28/2007 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Landover, MD 5 ☐ Other (Specify) 4 □Donation 21. Signature of uneral Service Licensee 22. Name and Address of Facility Johnson & Jenkins Funeral Home 716 Kennedy St. NW, Washington, DC 20011 rox 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Alzheimeris Physician reavs /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of requires that the death certificate be executed the attending physician and thed for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day 4☐Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one, Hospital: Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 1 ☐ Yes 2 → No 4- Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Director: After th 28b. Time of Injury 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: or Attending 1 Matural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specily) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospitel o within 24 hours aft To the Funeret Di **Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number September 26,2007 30. Name and address of person who complete cause of death (Item 23a) (Type, Print) Main MP MD 5) \ 7, bell 75 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar 2007

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State of Maryland / Department of Health and Ment	ai Hygienez	. U	ľ	3	1

Certificate of Death Rag. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Day Month **Physician** Robert. Louis Oakley ам September 29, 2007 11:35 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Shady Grove Adventist Hospital Rockville Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 6 Sex Birthplace (State or Foreign Country) **Funeral** Days Months 12 M 2□ F Yrs. 103-36-4688 Director 61 Nov. 6, 1945 New York Usual Residence of Decedent s filed within 72 hours after death with the Maryland I Hygiene.

The stan "natural," or Itams 23a or 28a-f ahow 10a, State 10b. County 10c. City. Town or Location 10d Inside City Limits the Medical Exeminer must be notified at 1 ☐ Yes 2 ☐ No Director Maryland Montgomery Germantown 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 18 Walnutwood Court 20874 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 💥o Specify: SpecifWhite Completed by If Yes, Give Year or Dates: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed v
Department of Health and Mental Hygiel
Important: if Itam 27 is marked other th
any injury or other traumatic avent, the 5+ Law Librarian University Law School 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Bert T. Oaklev ဂ Allese Duffin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara E. Oakley/Wife 18 Walnutwood Court, Germantown, MD 20874 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State October 3 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Metropolitan Crematory 4 ☐ Donation 5 ☐ Other (Specify) 2007 Alexandria, Virginia 22. Name and Address of Facility
Francis J. Collins Funeral Home Inc. 21. Signature of Funeral Service Licensee 500 University Blvd, W, Silver Spring, MD 20901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Septic Shock 4 Hours /Medical Due to (or as a consequence of): Examiner Staphylococcal Infection of Leg Sacuentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last 1 Month Due to (or as a consequence of): Hospital or Attanding Physician: The law requires that the death certificate be executed the burial-transit Quadriceps Tendon Rupture 2 Months Due to (or as a consequence of): Box 68760. attending physicien clan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) P.O. detached Physi 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 Tyes 2 No 3 Probably 4 Dunknown Completed Pulmonary Embolism 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes ②□No hes certificate Yes 2 □ No Be 25. Was case referred to medical 26. Place of Death Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ၉ 1 ☐ Yes 2 No this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Certification: 1 Natural 5 Pending within 24 hours after death.

To the Funeral Director: All completely filled in by the fu 1 Yes 2 No 2 Accident investigation 6 Could not be determined 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) tha 29b. Signature and title of cert 29c. License number 29d. Date signed (Month, Day, Year) e D26540 5 September 29, 2007 30. Name and address of person who completed cause of death (flem 23a) (Type, Print) Carl I. Schoenberg, 16220 Frederick Road Gaithersburg, MD 20877 M.D 31. Date filed (Month, Day, 32. Registrar's Signature State Gosale Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2007 33373

		1- For State Registrar		С	ertifica	te of	Death				R	eg. No.		•
Physici Medical Exami		Decedent's Name (First, Middle 1. Decedent's Name (First, Middle 2. Decedent's Name (First, Middle 2. Decedent's Name (First, Middle 2. Decedent's Name (First, Middle 2. Decedent's Name (First, Middle 2. Decedent's Name (First, Middle 2. Decedent's Name (First, Middle 2. Decedent's Name (First, Middle 2. Decedent's Name (First, Middle 2. Decedent's Name (First, Middle 2. Decedent's Name (First, Middle 2. Decedent's Name (First, Middle 2. Decedent 2. Dec	·	01.4.							Date of Dea Month	Day Yea	r	3. Time of Death 1620 hrs
	1161	Bedna I 4a. Facility Name (if not institution	n, give street and n	Obie umber)		41	. City, Tow	n, or Le	ocation of		Septembe	er 17, 2007 4c. County of	of Death	
		1437 Southern Avenu	e # 202				Oxon Hi					Prince G	eorge	's
Funeral Director		5. Social Security Number 243-40-8379	6. Sex	7. Age (In yrs			If Under 1 Months	Year Days	If Under Hours		8. Date of Bir Decemb	th (MM/DD/19/21)	Foreig	hplace (State or nRoxboro, untry)
		Usual Residence of Decedent	121 M 2 F			Yrs.						-,	COL	110 110 110 110 110 110 110 110 110 110
* any		10a. State 10b. County			ity, Town o		n				10			10d. Inside City Limits
Aaryland 28a-f show any 1 at once.	tor		e George	s 0x	ton H	ill 					25. 40	355	E	1 X Yes 2 No
215-0036 be filed within 72 hours after death with the Maryland tall Hygiene. Red other than "natural", or items 23a or 28a-f she ent, the Medical Examiner must be notified at once	Director	10e. Street and Number 1437 Southern	Ave #202				10f. Zip Co 207				1	0g. Citizen of Wh	at Coun	ntry?
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11215-0036 Id be filed within 72 h dental Hygiene. narked other than "n event, the Medical E.	Completed	Elementary/Secondary (0-12)	College (1-4 or 5+)		_	st of working itter	g lite. L		ise retired	a) : .	Federa	l Go	vernment
21215-0036 uld be filed within 7 Mental Hygiene. marked other than		17. Father's Name (First, Middle,				-		18	3.Mother's	Name (F	First, Middle, I	Maiden Surname)		
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JO Sation	ĭ	19a. Informant's Name/Relations Arlene Alexano		hter	97	720 I	ake E	Street a	and Numb	urt urt	#303,		ale,	MD20774
ore, Miles I and 2 sof Health an If item 27		20a. Method of Disposition 1 X Burial 2 Cremation	3 Removal f	04-44	cremato	ry or othe	on (Name or place)		1		Date 2/2007	20c. Location - Washing		/
Baltimore, permit Pages I a Department of He Important: If ite	-	4 Donation 5 Other Sp 21. Signature of Funeral Service			tenw		Cemet					The second second		
Baa permi Depa Impo injur		21. Signature of Furieral Service	Licensee									ington,		neral Nome 20011
Physician		23a. Part I. Enter the disease, or failure. List only one cause	complications that	caused the dea	th. Do not		mode of d	ying, sı	uch as car	rdiac or n				Approximate Interval Between Onset and
/Medical xaminer		Immediate Cause (Final disease or condition resulting in death)	a. Atheroscle	rotic Cardio	ovascula				Hadia.	1+,				Death
		: Sequentially list conditions,	b	a consequence	e of):									
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8760, tificate be ng physic as the bur	/Me	IF FEMALE: 23b. Was decedent pregnant in th		outcome of pro				2]e			23d. Date of		
O.O. Box 6876 that the death certificate hed by the attending phy detached for use as the	Physiciar	past 12 months?	4 Pregi	nant at time of	death 5		i death _{er} (Specify)	3	Ectopic	pregnand	У	Month	D	ay Year
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of Vital Records, ng Physician: The law requir ther this certificate has been si meral director, page 2 should t	To Be	examiner? 1 ✓ Yes 2 No	Hospital: 1	Inpatient 2	ER/Out	patient			ther:			Residence 6	Other:	Scene
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Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the burit	Medical C	29a Certifier	ysician: To the bearing											
To To con	Mec	29b. Signature and title of certifie	and manner s	stated.					number			29d. Date signe		
		Doma Mine	entimip.				O.C.M.E. September 18, 2007					007		
R (3)	1	30. Name and address of person Donna M. Vincenti, ME				111 F	Penn Str	eet. E	altimor	re, MD	21201			
St	ate	31. Date filed (Month, Day Yoar)		egistrar's Signa										
Regist	rar	UUI U I 2007	Dereva	· D.	March									

1. Decedent's Name (First, Middle, Last)

2. Date of Death 3. Time of Death 2<u>007</u> **Physician** Month NICHOLAS PALMIOTTO \mathbf{P}^{M} OCT 6 /Medical 2:57 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death NATIONAL NAVAL MEDICAL CENTER BETHESDA MONTGOMERY 5. Social Security Number 7. Age (In yrs. last birthday, 6. Sex If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Days Months Hours 1 M 2 F New York 11/18/1962 120-54-5792 44 Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d Inside City Limits a or 28a-f sho t be notified a VA Loudoun Sterling 1 ☐ Yes 2 ☐ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20166 USA 45550 Cheswick Park Court ral", or items 23a Examiner must b by Funeral 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Pages 1 and 2 should be filed within 72 hours after one of Health and Mental Hygiene. Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Yes 2X No Specify: Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Sr. Defense Modeler Sub Contractor 12 5+ 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be f Health and Menta item 27 is marked Pasquale Palmiotto Gabrielle Benda ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 45550 Cheswick Park Ct., Sterling, VA 20166 Janelle K. Palmiotto / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ite any injury or ot 1 Burial 2 K Cremation 3 ☐Removal from State Adams-Green Funeral 10/14/2007 Herndon, VA 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of 21. Signature of Funeral Service L of Facility 721 Elden St Chin Herndon, VA 20170 Adams-Green Funeral Home 23a. Part1. Enter the discusse, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** ACUTE MYELOGENOUS LEUKEMIA resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 ☐ Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an performed' 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one, Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 2 1 X Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 02002397A (IN) 20 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NATIONAL NAVAL MEDICAL CENTER LCDR USN ROBERT J. CARPENTER MC BETHESDA MD 20889-5600 32. Registrar's Signature 31. Date filed (Month, Day, Year) State OCT 1 7 2007 Registrar DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No 2007

33374

Physician /Medical Examiner certificate be executed Box 68760, P.O. Division or Vital Records, Physician: ō

use as the burial-trans and attending physician ρ signed by the a d be detached f has le 2 page certificate this funeral After death. within 24 hours after death To the Funeral Director: filled in by the

Physician

/Medical

Examiner

Funeral

Director

28a-f show

death \

should be filed within 72 hours after and Mental Hygiene.

marked other than "natural", or Itel

permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important; if Item 27 is marked oth any linury or other traumatic event one.

Baltimore, Maryland 21215-0036

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Completed

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ed other than "natural", or Items 23a or 28a-f sl event, the Medical Examiner must be notified

Physician/Medical in the past 12 months? 1 Yes 2 No 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Completed 25. Was case referred to medical examiner? Be 1 Yes 2 No P 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28h Time of 28d. Describe how injury occurred Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0057285 10/8/2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar

Keilpillar

31. Date filed (Month, Day, Year) 0CT 1 7 2007

Walnu

32. Registrar's Signature

#102

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Anastacio Ramos-Perez 2007 33376 1- For State Certificate of Death Rea. No Registrar

1. Decedent's Name (First, Middle,Last) 3. Time of Death 2. Date of Death Physician/ Month Day Year September 26, 2007 1955 hrs ANASTACIO RAMOS PEREZ **Medical Examiner** 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Montgomery Gaithersburg I-270 & Muddy Branch Road If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year **Funeral** Foreign Months Days Hours Min NONE Country) Honduras Director Dec/11/1961 1 **X**M 2 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 X Yes 2 No 23a or 28a-f show notified at once. Maryland Montgomery Gaithersburg with the Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20877 Honduras 9918 Killarney Lane # 201 百 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Funeral 12. Was Decedent Ever in U.S. 11. Marital Status Examiner must be Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 X Never Married 2 Married Yes 1 x Yes 2 No specify: Hondurian If Yes, Give Year Specify: Hispanic Widowed Divorced þ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry ages 1 and 2 should be filed within 72 hours ent of Health and Mental Hygiene.

nt: If item 27 is marked other than "natur; other traumatic event, the Medical Exami 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 Landscaping Landscaping, Co. 6th 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Roman Ramos Delfina Perez 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Marco Antonio Ramos 9918 Killarney Lane # 201 Gaithersburg, MD. (brother) 20b. Place of Disposition (Name of cemetery. 20c. Location - City or Town, State 20a. Method of Disposition crematory or other place) 1 X Burial 2 Cremation 3 X Removal from State Villanueva, Cortez 10/6/2007 Memorial San Ramon Donation 5 Other, Specify 22. Name and Address of Facility Santa Cruz Funerales Latinos, INC. 21. Signature of Funeral S 600 Kennedy ST, NW: Washington D. C. 20011 that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval 23a, Part I, Enter the disease, or complications Physician Between Onset and failure. List only one cause on each line /Medical Death a. Hanging Immediate Cause (Final disease caminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last nysician/Medical ing physician as the burial . UNPENDED AMENDED The law requires that the death certificate be Box 68760. 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy Year Live birth Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? ₽ P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. þ 1 Yes 2 V No 3 Probably 4 Completed Division of Vital Records, 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy has death? performed? 1 V Yes No ✓ Yes 2 26 Place of Death (Check only one) Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifi 25. Was case referred to medical Be Hospital: examiner? Nursing Home 5 Residence 6 ✔ Other: Scene Inpatient 2 ER/Outpatient 3 1 🗸 Yes No 28a. Date of Injury (Month, Day,Year) FOUND: 28d. Describe how injury occurred 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death Certification Subject hanged himself FOUND: Natural 1 Yes 2 V No Director: Pending Sep 26, 2007 1955 hrs 2 Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 🗸 Suicide Could not be or Town, State) I-270 & Muddy Branch Rd, Gaithersburg, MD determined (Specify) Woods Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier O.C.M.E. September 27, 2007 no 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Lina Li. MD

State Registrar

32. Registrar's Signature

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Day Year George Parker, Jr. Octobera F. 2007 12840AM /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Doctor's Community Hospital Lanham Prince George's If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6 SAV 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Days Months 1X M 2 □ F Hours Vrs Director 215-44-3133 61 June 9, 1946 Michigan Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 TxYes 2 □ No Directo Maryland Prince George's Lanham 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or be 9108 8th Street 20706 USA Funeral 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 □ Yes 2 No Specify. þ 3 ☐ Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Shipping and Receiving Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be George Freeman Parker Josephine Steklacic 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Josephine Parker 9108 8th Street, Lanham MD 20706 (Mother) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Chesapeake Crematory 10/3/2007 Beltsville, MD 21. Signature of Funeral Service License 22. Name and Address of Facility Rendon/Hale Funeral Home 9013 Annapolis Road, Lanham MD 20706 atenore 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** COMPONIA D Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last HETASTADE Examiner Due to (or as a consequence of): Physician/Medical If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 ☐ Other (specify) Dav 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No autopsy perform プランとうけんしょう 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

/Medical Examiner burial-tra Division or Vital Records, P.O. Box 68760. attending physician for use as the buris

the Maryland

should be fil**e**d within 72 hours after nd Mental Hygiene.

Maryland 21215-0036

Baltimore,

28a-f show

"natural",

To the I within 2 Registrar

State

31. Date filed (Month, Day, Year) OCT 0 3 2007

29a. Certifier (Check only one)

29b. Signature and title

32. Registrar's Signature MIRSON

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

722220

29d. Date signed (Month, Day, Year)

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Physicia	ın	1. Decedent's Name (First, Mid-									2. Date of De		25	YERO	3. Ti	o: 25
/Medica	al	JOSEPH HOWAR									9			^Y 2 *0 (// 1	0.23
Examine	er	4a. Facility Name (If not instituti The Pines (on, give Sene	esis Hea	1th	Care		ty, Town, o Casto						of Death		
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or 28	Director	10e. Street and Number					10f. 2	Zip Code				10g. Citi	zen of V	What Cou	ntry?	
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- 650 -		EILEEN HOBBS/	SIST	ER							SBURY,				,	
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Baltime permit. Pag Department Important: I eny injury o		21. Signature of Funeral Service	R	MEG	SCE	COM 2	200 2	• DAK	xr_{20L}	1 2T 1	& NEWN EASTON,	, MD	FUNE 216	RAL 1	HOME	PA
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To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page Medical Certification: To Be Com		29a. Certifier Check only one) Certifyin	ng Phys Examir	sician: To the best of ner: On the basis of and manner sta	examina	wledge, deat tion and/or in	h occurre vestigatio	d at the time n, in my op	e, date and inion, deat	d place, an	d due to the c at the time, d	ause(s) a late and p	and mar place, a	ner as stand	ited. the cau	se(s)
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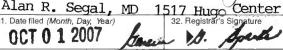
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year September 26, 2007 **Physician** 2:45 PM PERRY EDNA /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Holy Cross Hospital Silver Spring Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 6. Sex 8. Date of Birth (Month, Day, Feb 9 9. Birthplace (State or Foreign **Funeral** Days 1 □ M 2 □ XF 73 Yrs. 577-48-2872 Director 1934 Washington, DC Usual Residence of Decedent 10c, City, Town or Location 10b. County 10d. Inside City Limits show ral", or items 23a or 28a-f shov Ex-miner must be notified at Director 1 XYes 2 No Maryland Prince George's Temple Hills 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4004 Murdock Street 20748 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 【XNo If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 🛛 No Specify. þ 3 Widowed 4 Divorced 'natural", Year or Dates Completed traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) than College (1-4or 5+) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. Int; If item 27 Is marked other than Postage Stamp Supervisor Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Caldwell Dorothy Bernice 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lawrence E. Perry Husband 4004 Murdock Street Temple Hills, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages 1 Department of H Important; If ite any Injury or ot once. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Lincoln Memorial Cem. 10-4-07 4 ☐ Donation 5 ☐ Other (Specify) Suitland, MD 22. Name and Address of Facility Jordan Funeral Service, 21. Signature of Funeral Service Licensee 4001 Benning Road, NE Washington, DC 20019 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physiclan End Stage Interstitial Lung Disease disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of The law requires that the death certificate be executed that initiated events resulting in death) Last and -trar Due to (or as a consequence of): attending physician a for use as the burial-Division or Vital Records, P.O. Box 68760, Completed by Physician/Medical as IF FEMALE: 23c. If yes, outcome pf pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a ☐Yes 2X No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Cor Pulmonale 1 X Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed?
Yes 2 No or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 21X No မ 1X Inpatient 2 ER/Outpatient 3 DOA this within 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 1 🔀 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 🛛 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the

State Registrar 31. Date filed (Month, Day, Year) OCT 0 1 2007

29b. Signature and title of certifier



30. Name and address of person who completed cause of death (I em 23a) (Type, Print)

29c. License number

D52261

Silver Spring, MD

29d. Date signed (Month, Day, Year)

20906

September 26, 2007

Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760.

After

within 24 hours after death. To the Funeral Director: /

Medical 29b. Signature and title of certifier 30. Name and addess of person who completed cause of death (Item 23a) (Type, Print)

6 Could not be determined

3 Suicide

29a. Certifier (Check only one)

4 Homicide

29c. License number H0055751 29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

and manner stated

40900 Merchants Lane, Suite 205, Leonardtown, MD Jennifer Schmidt, D.O.

1 🗴 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

State Registrar

31. Date filed (Month, Day, Year) **DCT** 12



28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

07-07 Troy

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		- For State	Stati	e or ivial ylaria	Certi	ficate of	f Death		Reg. I	No		
Physician	n/		me (First, Middle,L	ast) K PLANTER,	SR				2. Date of Death Month Da October 4, 20	ay Year 007	3. Time of Death 0746 hrs	
Examin				give street and number)		T	4b. City, Town, or	Location of Deat		4c. County of Dea	oth	
	H		Regional Med				Saisbury			Wicomico	Piethologo (State of	
Funeral Director		5. Social Security 136-66-		Sex 7. Ag	ge (In yrs. las	t birthday) Yr	If Under 1 Yea Months Day		n. 8. Date of Birth (1 01/27	Fore	eign Country) VA	
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any		10a. State	10b. County	IMP-2	1	own or Loca					10d. Inside City Limit	
	5	VA	ACC	OMACK	AT	LANTI			100	Citizen of What C		
be filed within 72 hours after death with the Maryland mtal Hygiene. rked other than "natural", or items 23a or 28a-f she ent, the Medical Examiner must be notified at once ent, the Medical Examiner must be notified at once	Director	10e. Street and	Number				10f. Zip Code	22	1,09		,	
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within giene. her th	ompl	17 Father's Nat	ne (First, Middle, I	Last)				18. Mother's Na	me (First, Middle, Ma			
permit. Pages I and 2 should be filed within 72 hours after death wi Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items injury or other traumatic event, the Medical Examiner must be	Be Co	TOMMY BROWN					ROSEMARY PLANTER silling Address (Street and Number or Rural Route Number, City or Town, State, Zip Cod					
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State 31. Date filed (Month, Day, Year)
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stant Medical

37 Registrar's Signature

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year KATHRYN 09 **RUSSO** 10 07 0255 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death WMHS BRADDOCK CAMPUS CUMBERLAND ALLEGANY If Under 1 Year | If Under 24 Hrs. 6. Sex 8. Date of Birth (Month, Day, Year) Nov 6, 1944 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days Hours 1 ☐ M 2 ☐ F Μ̈́D 217-46-2110 62 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Allegany Cumberland 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21502 410 Park Street USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: white 3 Midowed 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) care provider self-employed 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) **Dorothy Wallace Dicken** Carl Dicken 19a. Informant's Name/Relationship (Type. Print) Dorothy Russo 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 211 W. Dillingham St. St. Mary's GA 31558 daughter 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State SS Peter Paul Cemetery 1 ☐Burial 2 ☐ Cremation 3 ☐ Removal from State 10/17/2007 MD Cumberland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Jurgers 22. Name Scarbelli Puneral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 pplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, y one cause on each line. 23a Part1. Enter the disease, or corshock, or heart failure. List only Approximate Interval Between Onset and Death Imme tote Cause (Final disease or condition disease or condition resulting in death) Alleed new Due to (or as a consequence of) Pto Goca Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last (or as a consequence of): ANDS Due to (or as a consequence of)

Examiner Division or Vital Records, P.O. Box 68760,

certificate has been signed by the attending physician and rector, page 2 should be detached for use as the burial-transit To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p

Physician

/Medical

Examiner

Director

Funeral

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Completed

Be

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Examiner

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Completed

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Certification:

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Director

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Pages 1 and 2 should be filed within 72 hours after death with nent of Health and Mental Hygiene.
ant: If Item 27 Is marked other than "natural", or items 23a or Lry or other traumatic event, the Medical Examiner must be It

permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: If Item 27 Is marked other any injury or other traumatic event, i

Physician

/Medical

Baltimore, Maryland 21215-0036

with the Maryland

•	d									
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ❷ No 9 □ Unknown	23c. If yes, outcome pf pregnation 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of continuous	al death 3 ☐ Ectopic pre			23d. Date of delivery Month Day Year					
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25. Was case referred to medical		26. Place of Death (Check only one)								
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27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investiga		28b. Time of lnjury M	c. Injury at Work? 1 ∐ Yes 2 ∐ No	28d. Describe how inj	ury occurred					
3 ☐ Suicide 6 ☐ Could no determin		ome, farm, street, factory,	office	28f. Location (Street a City or Town, Sta	and Number or Rural Route Number, ite)					
29a. Certifier 1 ☐ Certifying (Check only one) 1 ☐ Certifying	Physician: To the best of my know kaminer: On the basis of examina and manner stated.	owledge, death occurred at ation and/or investigation, i	t the time, date and place in my opinion, death occu	e, and due to the cause arred at the time, date a	(s) and manner as stated. und place, and due to the cause(s)					

29b. Signature and title of certifier

29c. License number

Seton Drive, Cumberland

29d. Date signed (Month, Day, Year)

who completed cause of death (item 23a) (Type, Print)

21502

State Registrar

31. Date filed (Month, Day, Year) OCT 1 7 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month 9, Jacqueline Yvonne Ross 2007 5:35 A^M October /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death St. Mary's Hospital Leonardtown St. Mary's 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** Birthplace (State or Foreign Country) 1□M 2XF Months Days Hours Min. 579-34-3187 Director 79 12/24/1927 Washington, DC Usual Residence of Decedent show s 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits If than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at Director 1 ☐ Yes 2 No Maryland Calvert Lusby 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 50 Appeal Lane 20657 Funeral United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian. Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 📉 No Specify. 2 Specify: 3 X Widowed 4 □ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any Injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) 12 Real Estate Manager Real Estate 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Delbert Rowe ပ Ida Maude Curtis 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lisa Ross Feusahrens/ Daughter P.O. Box 591, Solomons, Maryland 20688 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Pages ' 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Brinsfield-Echols Cr. 10/11/2007 | Charlotte Hall, MD 22. Name and Address of Facility Brinsfield Funeral Home, P.A. 21. Signature of Funeral Service Licensee Kyle S.Simons M01206 22955 Hollywood Road, Leonardtown, Marvland 20650 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due (or as Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine and (or as a co attending physician Physician/Medical the IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 🔯 No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a 9⊡Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2☐ No 24a. Was an page 2 certificate has autopsy perform 2**X** No director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٥ 1 ☐ Yes 2 No 1 X Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury 28b. Time of After Certification: 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 1 X Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No the Funeral Director:

certificate be executed Box 68760 Records, P.O.

with the Maryland

Maryland 21215-0036

Baltimore,

or Vital Physician: Division Hospital or Attending

> ပို ပ

death.

hours a

24

the

Medical

29a. Certifier

one)

3 Suicide

4 Homicide

29b. Signature and title of certifier

OCT

6 Could not be determined

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number 0

29d. Date signed (Month, Day, Year)

October 9, 2007

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Suresh Malik, M.D., P.O. Box 527, Leonardtown, Maryland 20650

31. Date filed (Month, Day, Year)

32. Registrar's Signature

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Certificate of Death

	1- For State Registrar	Ce	ertificate of Deatl	7	Reg		1 3330
Physician/ edical Examiner	Decedent's Name (First, M.	ilbert Josep	h Rosa	iolo	2. Date of Death Month September	Day Year 29, 2007	3. Time of Death 2343 hrs
	4a. Facility Name (if not instit Augustine Herman	tution, give street and number) Hwy		own, or Location of De	eath	4c. County of Death Cecil	
Funeral Director	5. Social Security Number 199 - 32 - 553 Usual Residence of Deceden	7 1 M 2 F		er 1 Year If Under 24 s Days Hours I	Min. 8. Date of Birth	(MM/DD/YYYY) 9. Birt Foreig Cou	
vith the Maryland s 23a or 28a-f show any audified at once.	10a. State 10b. Cou	nty 10c. Ci	ty, Town or Location		109	g. Citizen of What Cour	10d. Inside City Limits 1 Yes 2 No
th the Ma 23a or 23 notified 3		offdale Driv		17566	/ Coorife Von an No	USA	la dia Pladi
or item	11. Marital Status 1 Never Married 2 3 Widowed 4	12. Was Decedent Ever in Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	If Yes, specif	nt of Hispanic Origin? y Cuban, Mexican, Pue No specify:		White, etc.	can Indian, Black,
nore, MD 21215-0036 att of Health and 2 should be filed within 72 hours after att of Health and Mental Hygiene. tt If Item 27 is marked other than "natural", other traumatic event, the Medical Examiner To Be Completed by	15. Decedent's Education (: Elementary/Secondary (0-	Specify only highest grade completed) 12) College (1-4 or 5+)	16a. Decedent's Usual during most of wor	king life. DO NOT use		16b. Kind of Business/li	HATTINU
D 21215-0036 should be filed within 7 and Mental Hygiene. 7 is marked other than natic event, the Medical To Be Comple	17. Father's Name (First, Mid	1		18.Mother's Na	ame (First, Middle, M	Hopper	5
- p # E #	19a. Informant's Name/Relating Janet Van 20a. Method of Disposition	ionship (Type, Print)	19b. Mailing Address	(Street and Number	or Rural Route Numb	per, City or Town, State AREA I ILE. 20c. Location - City or	MD 21784
트리얼등등	1 Burial 2 Crema 4 Donation 5 Othe	ation 3 Removal from State er Specify	crematory or other place)	rematory l	10-8-07	Leola P.	· =
Baltii permit. Departm Importa	21 Signature of Funeral Sen	LACTOR SOOL	Lee A. Perryy	ille. Mary	land 2190:		
Physician Medical Fxaminer	failure. List only one ca Immediate Cause (Final dise	_{ease a.} Multiple Injuries	ath. Do not enter the mode of	of dying, such as cardia	ac or respiratory arre	st, shock, or heart	Approximate Interval Between Onset and Death
	or condition resulting in deat Sequentially list conditions,	b.					
red Insit	if any, leading to immediate cause. Finer linderlying Co (Disease or injury that initiate events resulting in death). Le	ed C.					l
760, ficate be executed 3 physician and the burial - transit	UNPENDED	d. AMENDED					
cox 68 eath certil eath certil catending for use as	IF FEMALE: 23b. Was decedent pregnant past 12 months?	23c. If yes, outcome of pr	2 Fetal death	3 Ectopic pre	egnancy	23d. Date of delivery	/ Day Year
ords, P.O. Bc w requires that the des as been signed by the s should be detached fic pleted by Phys		enditions contributing to death but no	ot resulting in the underlying	cause given in Part I.		pacco use contribute to	
of Vital Records, P.O. ng Physician: The law requires that the After this certificate has been signed by meral director, page 2 should be detach in: To Be Completed by P.	H				24a. Was a autops perform	y prior to o ned? death?	topsy findings available completion of cause of
tal Recitian: The lactor, page	25. Was case referred to me examiner?	Hospital:		26.Place of Death (Che			
of Viting Physic After this funeral dirt.	1 ✓ Yes 2 No 27. Manner of Death	28a. Date of Injury		OA Other 4 Nu 28c. Injury at Work?	28d. Describe h	Residence 6 Other	
Division tal or Attendin rs after death. at Director: A led in by the fu		Pending Sep 29, 2007	2341 hrs	1 Yes 2 ✔ No		o involved in collis	
Division o Hospital or Attending 44 hours after death. Funeral Director: Afterly filled in by the fune	4 Homicide	Could not be determined (Specify) Local Str	t home, farm, street, factory reet	, office building, etc.	or Town, St		ral Route Number, City d.
To the Hosp within 24 hr To the Fun completely i	one) 2 Medical	ng Physician: To the best of my knowle Examiner:On the basis of examination and manner stated.	n and/or investigation, in my	opinion, death occurr		nd place, and due to th	e cause(s)
ž	29b. Signature and title of ce	IM.		O.C.M.E.		September 30, 2	•
20	1	rson who completed cause of death (It Deputy Chief Medical Examin	ner 111 Penn Stree	et, Baltimore, MD	21201		
State Registrar		ear) 2. Registrar's Sign	ature facility				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 33385 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Stephen Nolly Rivero October 2007 4:20 A /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Casey House Montgomery Derwood If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year, July 28, 1 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday 9. Birthplace (State or Foreign **Funeral** 1 X M 2 □ F 62 1945 Director 577-78-1348 Peru Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show an injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits Director 1 ☐ Yes 2 ▼No Montgomery Gaithersburg 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 15404 Peach Leaf Drive 20878 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 ∑Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1971 Baltimore, Maryland 21215-0036 1 XYes 2 □ No Specify: Peruvian White \$ 3 Widowed 4 Divorced 1973 Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Electrical Engineer NIH 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Isaac Rivero Trinidad Ugarte ျှ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Morena Rivero / Spouse 15404 Peach Leaf Drive, Gaithersburg, MD 20878 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 ☐ Burial 2
☐ Cremation October 5 3 ☐ Removal from State Metropolitan Crematory 4 □ Donation 5 □ Other (Specify) 2007 Alexandria, Virginia 22. Name and Address of Facility DeVol Funeral Home, 10 East Deer Park Drive, Gaithersburg, MD 20877 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Colon Cancer /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last and burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, the attending physician hed for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 □Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknowr sate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an certificate has perform 2 X No 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 NOther (Specify) Hospice မ 1 ☐ Yes 2 ☑ No this 28a. Date of Injury (Month, Day Year) 27. Manner of Death Hospital or Attending P 24 hours after death. Funeral Director: After ti 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Certification: 5 Pending investigation 1 X Natural 2 ☐ Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the Hospital or within 24 hours af To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only

Registrar

one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year) OCT 03 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Genevieve Wroblewski, M.D., 1355 Piccard Drive, Suite 100, Rockville, MD 20850 32. Resistrar's Signature

wo

29c. License number

D0064615

29d. Date signed (Month, Day, Year)

October 2, 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amend Item 8 per fh, g878,04/11/08dhb Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** MUSSE Nollier 2007 0 n SEPT. 035 /Medical Eacility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Peninsula REGIONAL Mormica MEDICAL CENTER bure 6. Sex 7. Age (In yrs. last birthday) If Under 24 H rs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 1 F 01/28/1925 Months Days Hours Min -20-3916 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at **Funeral Director** 1 √ Yes 2 No Hccomack hincoteag death with the 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? d 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race 11. Marital Status American Indian Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Yes 2 Yes Year or Dates: 1 ☐ Never Married 2 CMarried Baltimore, Maryland 21215-0036 1 ☐ Yes 2 The No Specify Completed by Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be and Mental H Jalker ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) item 27 I Husband hincotragur, UA a333L 20c. Location - Sity or Town, State Harold 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date Department of H Important: If ite any Injury or ot once. 1 XBurial 2 ☐ Cremation 3 ☐Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Taylor Cemalay 22. None and Address of scility Temperanceuille, UA VA 33336 10/2/07 permit. 21. Signature of Funeral Service Licensee 6327 Church St. Chinadaya Juneral Home 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last as a consequence of) Examine The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Box 68760. Physician/Medical as attending IF FEMALE: use 23c. If yes, outcome pf pregnancy
1 □ Live birth 2 □ Fetal death
4 □ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 5 ☐ Other (specify) P.O. this certificate has been signed by the a ral director, page 2 should be detached it 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, <u>م</u> 1 Yes 2 No 3 Probably 4 donknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 2 No I or Attending Physician: after death. 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? Hospital: Other: 1 ☐ Yes 2 10 1 Inpatient 2 ER/Outpatient 3 DOA 2 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural
2 Accident (Month, Day Year) Injury To the Hospina. ... within 24 hours after death.

To the Funeral Director: After a To the Funeral Director: After a To the Funeral Director. 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Extifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) and address of person who completed cause of death (Item 23a) (Type, Print) LISCHICK, MID. SALISBURY MO 100 E. CARROLL 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

OCT 0 1 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 7 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) September 18,2007 **Physician** Roundtree Eugene Everett 2:12 P M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Prince Georges 582 Wilson Bridge Dr. Apt#1 Oxon Hill If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 08/27/1951 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number 6 Sax **Funeral** Months 1 M 2 □ F Washington, DC 56 263-96-0806 Director Usual Residence of Decedent filed withIn 72 hours after death with the Maryland 10d. Inside City Limits 10b. County 10c. City. Town or Location 10a State ?7 is marked other then "neturel", or items 23a or 28a-1 show traumatic event, I'm Medical Exactications by recitified at MD Prince Georges Oxon Hill 1X Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20745 USA 582 Wilson Bridge Dr. Apt#1 Completed by Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married Specify: Black 1 Yes 2X No Specify: 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) al Hygiene. $\stackrel{\text{Elementary/Secondary (0-12)}}{\text{12th}}$ College (1-4or 5+) Private Information Technologist 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be and Mental I and 2 should be Unknown Emma Jane Roundtree 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12517 Proxmire Dr., Ft. Washington, MD 20744 Health Item 27 i Robin Printis/ Ex-Wife other 1 20b. Place of Disposition (Name of cemetery, crematory or other) Date 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 ment of F tent: If It 1 XBurial 2 Cremation 3 Removal from State Lincoln Memorial Cem. 09/24/2007 Suitland, Maryland Department of Importent: If eny injury or once. * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Johnson & Jenkins Funeral Home 21. Signature of Funeral Service License 716 Kennedy St. NW, Washington, DC 20011 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Cardiac Arrest disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Atrial Fibrillation Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner certificate be executed burial-transit Hypertension resulting in death) Last Due to (or as a consequence of): attending physician Chronic Kidney Failure Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? Month for Day 5 Other (specify) 4☐Pregnant at time of death the 9 Unknown þ 23e. Did tobacco use contribute to the cause of death? signed be del Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Systemic Lupus Erythematosis 1 Yes № No 3 Probably 4 Unknown Be Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autonsy partorn 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2X No 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: Other: 1 Tes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 🔀 Residence 6 ☐ Other (Specify) Certification: To

o. 0 of Vital Records, Physicien: director this funeral After Division à

Baltimore, Maryland 21215-0036

or Attending after death. Hospite within 2

DHMH 17 Rev 1/2001

Daniel A. Nash Jr. M.D. OCT 0 1 2007 State Registrar

29b. Signature and title of certifier

27. Manner of Death

1 X Natural

3 Suicide

29a, Certifier

Medical

2 Accident

4 Homicide

(Check only one)

5 Pending investigation

6 Could not be determined

30. Name and address of person who completed cause of death (Item

(Item 23a) (Type, Print) 6192 Oxon Hill Rd. #207, Oxon Hill, MD 32. Registrar's Signature

28a. Date of Injury (Month, Day Year)

and manner stated

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c.

1 🕰 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

D 0020752

Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year) 09/27/2007

20745

Registrar

State

31. Date filed (Month, Day, Year)

32. Registrar's Signatur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 2001 /Medical 4a. Facility Name (If not institution, give street and number) City, Town, or Location of Death 4c. County of Death **Examiner** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foleign Country) If Under 1 Y Age (In yrs. last birthday **Funeral** Months Davs Min. 1 □ M 2 💢 F Hours Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 XYes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ISA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) . Race - American Indian, 11. Marital Status Black, White, etc. 72 hours after 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. 2 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) filed within Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) a 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be nent of Health and Mental sborne Minnie 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health a Important: If Item 27 is any Injury or other trau 9505 Beech Park St. C Lurvelma Love 20c. Location - City or Town, State 20a. Method of Disposition Place of Disposition (Name of cemetery, crematory or other place) 1 XBurial 2 □Cremation 3 □Removal from State 10-8-07 Alexandria, VA 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Greene Funeral Home 21. Signature of Funeral Service Licensee Nelm & Street 814 Franklin Street. Alexandria VA 22314 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated exerts. Due to (or as a consequence of): Examine requires that the death certificate be executed burial-transi that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 2 No ed by the a o. 9 Unknown 9 Unknown signed by to be to be to be the detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed been 24b. Were autopsy findings available prior to completion of cause of death? The law 24a. Was an has autopsy certificate 2 No 1 ☐ Yes 2 No 1 ☐ Yes or Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 1 ☐ Yes 2 🔀 No 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) P 2 ER/Outpatient 3□ DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t Certification: Division To the Hospital or Attending 1 X Natural 5 Pending Injury death. 1 ☐ Yes 2 ☐ No investigation Director: 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide hours after fo the.
within 24 hour.
*he Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year,

OCT 0 3 2007

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32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2007 33390 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Physician September 29, 2007 10:10 AM Marie Julia Silberzahn /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner 5 Wilderness Road E1kton Cecil If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days 1□M 2XF 4, 212-05-7815 90 Maryland Director Feb. Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2 X No Director Maryland Ceci1 E1kton 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21921 5 Wilderness Road United States Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White Completed by 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be David Gunter Julia (Unknown) 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Robert L. Silberzahn / Son Wilderness Road, Elkton, Maryland 21921 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition October 1 ☐ Burial 2XX remation 3 ☐ Removal from State Mayerdale Crematory 1, 2007 Newark, Delaware 4 □ Donation 5 □ Othe 21. Signature of Funcia 22. Name and Address of Facility Crouch Funeral Home 127 South Main Street, North East, Maryland 21901 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical onsequence of): Due to (or as a Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner nding physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4☐ Pregnant at time of death 5 ☐ Other (specify) 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Donknown 1 Tes 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 ☑ No 24a. Was an 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 3 Residence 6 Other (Specify) 1 | Yes 2 | No 1 | Inpatient 2 □ ER/Outpatient 3 □ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1. ☐ Matural 2 ☐ Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide determined

Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, s after death.

I Director: After this of in by the funeral d within 24 hours a

Certification: To 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D0024183 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 1/2001

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E 32. Reistrar's Signature

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Lue North EAST Md

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State Registrar 29b. Signature and title of certifier

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year) Registrar's Signature OCT 0 1 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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and manner stated.

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29d. Date signed (Month, Day, Year)

RN ST, SUIT-2, CAMBRIDGE, MD-21613

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiere 0 0 7 33392 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Year September 27, 2007 Evelyn Viola Simonds 11:15 pm /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death National Lutheran Home Rockville Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1 ☐ M 2 🖺 F Min. Director 577-32-2948 Yrs. 91 March 10, 1916 District of Columbi Usual Residence of Decedent with the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.
Importent: if item 27 is marked other than "natural", or itams 23a or 28e-f show may jury or other traumatic avant, the Medicul Examilian must be notified at once. 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits Director 1 ☐ Yes 2 No Maryland Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9701 Viers Drive Funeral 20850 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11, Marital Status Black, White, etc. 1 ☐ Yes 2 ☒ No ff Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🖾 No þ Specify. 3 X Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Secretary U.S. Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Melvin Redmond Annie R. White 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Clayton Williams - Son 252 Candlewood Drive, Conway, South Carolina 29526 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery crematory or other place)
Maryland's Veterans Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Cheltenham 4 ☐ Donation 5 ☐ Other (Specify) Cemetery 10/03/2007 Hurlock, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Avenue, Silver Spring, Maryland 20904 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or yeart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician ALZHEIMERS DEMENTIA /Medical Due to (or as a consequence of): Examiner ANOREXIA Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine been signed by the attending physicien and should be detached for use as the burial-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of). Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Month Day 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 ☐ Yes 2 ÑNo 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Wasan certificate 1 ☐ Yes 1 ☐ Yes 2 ☐ No 2 No To the Hospitel or Attending Physician: "within 24 hours after death."

To the Funerel Director: After this certifica 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA After thi funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: 1. Natural 5 Pending Injury investigation nerel Director: A filled in by the fi 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Mulle De

State Registrar VATTI ANTHONY

31. Date filed (Month, Day Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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VEIRS DRIVE 32. Poistrar's Signature

MP

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

DOO 51158

ROCKVILLE

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SEPTEMBER

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			1 - For State Registrar	State of Maryland	l / Depa <i>Cer</i> i	rtment of H	ealth and N Death		ien@ () 19. No.	07	33393
			1. Decedent's Name (First, Middle, La	st)				2. Date of Deat Month	h Day	Year	3. Time of Death
	Physici /Medi		JAMES WILLIAM	STRICKLAND				SEPTEMBE	R 25,	2007	9:45 Ам
j.	Examir		4a. Facility Name (If not institution, give	e street and number)		4b. City, Town, or	Location of Death		4c. Count	ty of Death	
			5728 Eagle Street			Capitol	Heights	T	Prin	ice Ge	orge's
	Funeral		Social Security Number 6. S	Sex 7. Age (<i>in yr</i> s. <i>ia</i> I⊊M 2□F 76	Yrs.	Il Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day,			lace (State or Foreign try)
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	the 28s	Director	10e. Street and Number	O .		10f. Zip Code		10	Og. Citizen of	What Coun	itry?
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	filed within 72 hours after deeth with the Maryland Hygiene. thar then "natural", or items 23a or 28e-f show sht, I'm Medical Example must be notified at		17. Father's Name (First, Middle, Last)		1	18. Mother's Nam	e (First, Middle, M	Maiden Suma	ime)	
au	Mental I	Be C					Toyon	Ann Whit	Δ.		
Maryland	should ind Men marka umatic	2	William Jasper S		19b. Mailing	Address (Street a	and Number or Rui			n, State, Zip	Code)
S	end 2 saalth ar n 27 le		Wanda Lee Strick		5728	Eagle St	. Capitol	Heights	, MD 2	20743	
စ်	Hea Hea tem		20a. Method of Disposition			ition (Name of atory or other plac			20c. Location		wn, State
9	Pages nent of int: if it		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special	JRemoval from State			nt. Oct.	5 2007	Grahan	n. N.C	! <u>.</u>
Baltimore,			21. Signature of Funeral Service Fice		22.	Name and Addres	s of Facility Ste	wart Fun	eral H	lome.	Inc.
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Вох	atten for u	ian	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2 Fetal of 4 Pregnant at time of de	déath 3 ☐t	Ectopic pregnancy Other (specify)				onth don't	Day Year
o.	0 0	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown	u 0	Caror (speciny)					
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of	er thi		27. Manner of Death		28b. Time of Injury	28c. Injun Won		28d. Describe ho			
Ö	Attending r death.	atlo	1 Anatural 5 ☐ Pending 2 ☐ Accident investigation		injury		Yes 2 □ No				
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	the single	Medicai	one)	and manner stated.		29c. License			9d. Date sign		
	S t s	-	29b. Signature and title of certifier	cketne ux.		MD# 3		1	EPTEMB		
								31		LIN 20;	, 2007
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KAREN ANN BLACKSTONE, M.D., VAMC, 50 IRVING STREET NW, WASHINGTON, DC 20						2042	2/688				
	Sta	ite	31. Date filed (Month, Day, Year)	32. Registrar's Signati	ure						
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			Please Type or Print in Black Inc State of Maryland / Depa	stment of Health and Mar						
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ă.	Physici /Medi		Decedent's Name (First, Middle, Last) Thelma R. Tayman	5	Date of Death Month Prember	Day Year 4 20 PM				
*	Examir Funeral	ner	4a. Facility Name (If not institution, give street and number) Doctors Hospital 5. Social Security Number 6. Sex 1 M 2 XF 7. Age (In yrs. last birthday) 1 M 2 XF 7. Yrs.	Lanham If Under 1 Year If Under 24 Hrs. 8.	Date of Birth	Prince George's 9. Birthplace (State or Foreign				
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	h with the 23a or 28a st be noti		10e. Street and Number 12507 Hilltop Lane	10f. Zip Code 20720		Citizen of What Country?				
	72 hours after death with the Maryland natural", or items 23a or 28a-f show dical Examinar must be notified at	by Funeral	1 Never Married 2 Married 1 Tyes 2 No	Vas Decedent of Hispanic Origin? (Specifi Yes, specify Cuban, Mexican, Puerto Ric	dent of Hispanic Origin? (Specify Yes or No- cify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American In Black, White, etc. 2 No Specify: White					
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	ould be file Mental Hy larked oth	To Be (17. Father's Name (First, Middle, Last) James Herbert Fowler 18. Mother's Name (First, Middle, Maiden Surname) Helen Ruth Hatton							
	I and 2 sh lealth and im 27 Is m ther traum		James P. Tayman / Husband 12507	g Address (Street and Number or Rural R Hilltop Lane, Bowie	e MD 2072	20				
altimore,	t. Pages introduced the result of the result		4 Donation 5 Other (Specify)	in Cemetery Oct 1, 2007	Bre	Location - City or Town, State				
Ba	permi Depa Impo any ir			Name and Address of Facility Beal 5512 NW Crain Hwy. I	Bowie MD	20715				
)	Physician /Medical		shock, or heart failure. List only one cause on each line,	HOSCS due to un		Approximate Interval Between Onset and Death				
P.O. Box 68760,	Examiner	iner	Sequentially flet conditions, if any, leading to immediate h Remail FM	Renal FAILUR Hepatorenal Syndrome						
	eath certificate be executed attending physician and for use as the burial-transit	lical Examine	cause (bisease or injury that initiated events resulting in death) Last c	c						
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Recol	The law require ate has been six bage 2 should b		Atrial Fibrillation		24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?					
Division or Vital Records,		To Be	Sepsis due to peritonitis 25. Was case referred to medical examiner? 1 \(\text{Yes} \) 2 \(\text{No} \) \(\text{Hospital:} \) 1 \(\text{Minpatient} \) 2 \(\text{ER/Outpatient} \)		Check only one) 5 □ Residence					
ision o	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director, I	Certification:	27. Manner of Death 1 Natural 5 Pending (Month, Day Year) 2 Accident investigation 3 Suicide 6 Could not be determined	M 1 Yes 2 No	I. Describe how inj	iury occurred and Number or Rural Route Number,				
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X Q Q	death certificate e attending phys d for use as the	ian/	23b. Was decedent pregnant in the past 12 months?	ve birth	2 ☐ Fetal	death	3 ☐ Ectopic pregnancy	,			23d. Date of del Month	ivery Day Year	
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1	B		30. Name and address of person who completed of				. 1	C	NO	7	0646	, , , , , , , , , , , , , , , , , , , ,	
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DHA	Registr		001 0 0 2001			~	April						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amend #205 - State FH TCHD 10/09/07 pha Amend #15 - Registrar FH TCHD 10/08/07 pha 1. Decedent's Name (First, Middle, Last) Certificate of Death 2. Date of Death 0230AM M SEPTEMBER 30 2007 PETER S. THOMPSON 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death TALBOT 9729 FAIRVIEW POINT LANE EASTON If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Days Months Hours 1 XM 2 □ F **NEW YORK** 89 DEC. 8, 1917 168-14-7717 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2 XNo MD TALBOT EASTON 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 9729 FAIRVIEW POINT LANE 21601 USA 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 X Yes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify Specify: WHITE 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 STOCKBROKER FINANCIAL 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) WILLIAM L. THOMPSON MARTHA GROOME 19h Maijing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Brooks DriveroSuite 1020 Easton, Md 21601 19a. Informant's Name/Relationship (Type. Print) K. THOMAS EVERNGAM, JR/PER.REP 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition Date 10/08/07 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State CHESAPEAKE CREMATION CTR. 10/3/07 STEVENSVILLE, MD 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licenses FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA Ostrough C.F.S.P. Jasqoh 200 S. HARRISON ST EASTON, MD 21601 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final PANCAPATIC disease or condition resulting in death) monTH Du no (or as a consequence of). Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 100 3 Probably 4 ☐ Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy performed this certificate 1□ Yes 2 1No or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one)

Medical Certification: To

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 🔲 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 5 ☐ Pending Investigation (Month, Day Year) Injury 1 Natural 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

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funeral

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within 24 hours a

To the Funeral I

completely filled Hospital

> EGLSEDER, LUDWIG J. 31. Date filed (Month, Day, Year)

OCT 0 2 2007

30. Name and address of person who completed pause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

egistrar's Signature

III M.D. 503 CYNWOOD DR., EASTON, MD 21601

29c. License number

29d. Date signed (Month, Day, Year)

Registrar

Box 68760. PO Division or Vital Records,

Saltimore, Maryland 21215-0036

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24 hours a Funeral I

29a. Certifier

29b. Signature and ti

State Registrar

Medical

24035 Three Notch Road OCT 1 0 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Vinod K. Shah, M.D.

and manner stated.

Hollywood, MD 20636 egistrar's Signature

1 Detrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 3, 2007 ear October ROGERS HALL THACKABERRY 10:15 A M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4h. City. Town, or Location of Death **Examiner** Buckingham's Choice Health Center Frederick Adamstown If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) New Jersey 6. Sex 8. Date of Birth (Month, Day, Nov. 29, 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1₩ 2□F 152-22-4540 Nov. **Director** Usual Residence of Decedent filed within 72 hours after death with the Maryland r 28a-f show notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2 ☐ No Director Maryland Frederick Adamstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? an "natural", or items 23a or Medical Examiner must be 21710 6810 Shenandoah Court U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ★1 Yes 2 □ No If Yes, Give Year or Dates: WWII Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: þ 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) the Civil Engineer Engineering 7 is marked other traumatic event, th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) s 1 and 2 should be fill Health and Mental H tem 27 is marked oth Be William J. Thackaberry Florence Hall ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1979 Greenbrook Blvd, Richland, Washington 99352 Department of Health Important: If item 27 any injury or other the William S. Thackaberry / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Pages 1 1 ☐ Burial 2X Cremation 3 ☐ Removal from State Smithsburg Crematory | 10/5/07 Smithsburg, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral S 22. Name and Address of Facility
ROBERT E. DAILEY & SON, FUNERAL HOMES, P.A. 1201 NORTH MARKET ST., FREDERICK, MD 21701 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or beart failure. List only one cause of each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 5-6 Doys pneumania /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) requires that the death certificate be executed that initiated events resulting in death) Last burial-tra Due to (or as a consequence of) Box 68760. physician Physician/Medical the attending p as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) P.0. the 9 Unknown s been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 2 2 No 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes Fundramo 15 D/45+10 Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has le 2 s autopsy perform page certificate Division or Vital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No P 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one)

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day, Year

5h04

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29d, Date signed (Month, Dav. Year)

Division or Vital Records, P.O. Box 68760,

		1 - State Registrar	State of Maryland		tificate of			Reg. N	2007	33399
Physicia	_	Decedent's Name (First, Middle, Las RAYMOND	THOMAS				2. Date of I		ጛ, 200	3. Time of Death 7 1:35Р м
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Funeral	4	Social Security Number 6. Security Number	7. Age (In yrs. Is		If Under 1 Year Months Days	-	rs. 8. Date of I	Birth Day, Year		thplace (State or Foreign
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Maryland a-f show ified at	ctor	MD 10b. County Montge		, Town or Loo	silver S	Spring				10d. Inside City Limits 1 ☐ Yes ② No
MD Montgomery Silver Spring 10e. Street and Number 2921 N. Leisure World Blvd, #425 20906 11. Marital Status 1 Never Married 2 Married 1 Yes, specify Cuban, Mexican, Puerto F								10g. C	Citizen of What Country? U.S.A.	
urs a	þ	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.8 Armed Forces? 1 ☐ Yes M☐ No If Yes, Give Year or Dates:		Was Decedent of H f Yes, specify Cub I ☐ Yes 2 ☑ No		(Specify Yes or I erto Rican, etc.)	No-	14. Race - Ame Black, Whit Specify:	
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permit. Departi		21. Signature of Funeral Service Lice	Tuond							MD 20850
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The law requires that the death certific tte has been signed by the attending p bage 2 should be detached for use as i	ıysician/№	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome pf pregnal 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de 9 □ Unknown	death 3	Ectopic pregnand Other (specify)	у			23d. Date of de Month	livery Day Year
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		30. Name and address of person who				wah Di-	Fr.	.1	110 MD	20850
Sta	te	Anurita Mendh 31. Date filed (Month, Day, Year) CCT 0 3 2	32. Registrar's Signat	Z4U J	kesea:	CU BTA	va, koc	V/T	TTE,MD	20050
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State of Maryland / Department of Health and Mental Hygienes 33400 Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) OCT. **Physician** Thomas Violet Marie 05, 2007 9:20 A M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Caroline Denton Caroline Nursing Home If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplece (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) June 19, 19 **Funeral** 1 ☐ M 2 🕱 F 84 215-16-3119 Yrs 1923 Virginia Director June Usual Residence of Decedent the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location or 28a-f show event, the Medical Examiner must be notified at 1 ☐ Yes 2√ No Preston Caroline Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21655 23177 Hog Creek Road United States or itams 23s death Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 2**7** No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: White þ 3

Widowed 4

Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. important: if item 27 is marked other than any niury or other treumatic avent, it a Me and other. Elementary/Secondary (0-12) College (1-4or 5+) Agriculture Farmer 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be James Albert Alderman Shrilda Keene 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William R. Thomas, Sr./Son 23251 Hog Creek Road, Preston, MD 21655 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 IX Burial 2 ☐ Cremation 3 ☐ Removal from State Junior Order Cemetery 10/10/07 Preston, Maryland * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Framptom Funeral Home, 216 N. Main St., Federalsburg, MD 21632 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ESTIL Cona /Medical Due to (or as consequence of): Examiner Securities in conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner g physicien and as the burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760 Physician/Medical use as the attending IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 1 Live birth 2 ☐ Fetal death in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 3 Probably 4 Unknown Completed been 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No certificate has page 1 ☐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one, Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Jursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No Certification: To 27. Manneg of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how infury occurred After 1 (Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A investigation 2 Accident the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20 31. Date filed (Month, Day, Year) 32 Registrar's Signature State OCT 1 1 2007 Registrar

5 AS DHMH 17 Rev 1/2001

			1 - For State Registrar	State	of Maryl	land / Depa	artmer <i>rtificat</i>	t of H e of L	ealth a Death	and M	Mental I		ne2 0	07	3340	1
	Physicia /Medic		1. Decedent's Name <i>(First, Middle, I</i> Epifania	Last)	•		V	aril	la		2. Date of Month		20 07	Year	3. Time of Deat 3:20 A	h M
	Examin		4a. Facility Name (If not institution, g Shady Grove Nursing		ımber)		4b. City, Town, or Location of Death Rockville						4c. County of Death Montgomery			
	Funeral Director			.Sex 1 □ M 2 □ XF	7. Age (In	yrs. last birthday) Yrs.		1 Year Days		24 Hrs. Min.	8. Date o	f Birth		9. Birth	place (State or Fore ippines	eign
			Usual Residence of Decedent 10a. State 10b. County		100	: City, Town or Lo	cation					,,			10d. Inside City Lin	nits
	a-f eho	ctor	Maryland Montg	omery		Germantow									1 □ Yes 2 X	
	with the	by Funeral Director	10e. Street and Number 18239 Smoke House Co	urt			10f. Zip	Code 20874				10g	. Citizen of	What Cou	,	
	r death	ınera	11. Marital Status	12 Was Dec	cedent Ever orces?	in U.S. 13.			spanic Ori	gin? (Sp	ecify Yes o	r No-	14. Ra		can Indian,	
030	ours afte rel', or It Exercin	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 □ Yes If Yes, G Year or f	ive		1 ☐ Yes		Specify:				Specia		ilipino	
1215-0036	in 72 ho n "natu	Completed	15. Decedent's (Specify only highest)	grade completed,		16a. Dece (Give lite.	dent's Usu kind of wo DO NOT u	al Occupa rk done d se retired	ition uring mos	t of work	ing	16	b. Kind of E	Business/Ir	ndustry	
717	ed with yglene. ner than	Comp	Elementary/Secondary (0-12) 6th		(1-4or 5+)		lomemal						In Ho			
yıand	uld be fill fental H rked ott tic even	To Be	17. Father's Name (First, Middle, La Felix Espina	st)					Engra		e (First, Mil Geroi		iden Sumai	me)		
Mary	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heelih and Mental Hyglene. Importaent: if tiem 27 is marked other than "naturel", or items 23a or 28a-f show eny injury or other treumatic event, the Modical Examinar must be notified at 90ce.		19a. Informant's Name/Relationship Victoria Varilla /		-		•	,			al Route No		ity or Town			
ore,	of Heel of Heel fitem 2 r other		20a. Method of Disposition 1 Burial 2 Cremation 3			Ob. Place of Dispo cemetery, crei	sition (Na/	ne of	1		Date		c. Location	208 - City or T		-
Бащтог	nit. Pag artment ortent: injury c		4 Donation 5 Other (Spe	cify)	F	Himlayang I				10/08	/2007	Que	ezon Ci s Fune	ty, P	nilippines	
ñ	Depa impo eny ir		> 1 1. Kels	-		6	160 Ox	on Hi	II Roa	d Oxc	on Hill	, Mar	yland	2074		
	Physician		shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition CONCESTIVE HEART FATTURE 1 month												Approximate Interval Between Onset and Death	
	/Medical Examiner		resulting in death)	a		rsequence of):	TALLO	NE .							1 month	
H	D #	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b	(or as a cor	nsequence of):	+					**				
5	execute on and ial-trans	Examiner	cause (Disease of Injury that initiated events resulting in death) Last	c	(or as a cor	nsequence of):										
8/00,	physicies the burns the burns	Physician/Medical		d												
o Xoo	th certifi tending r use as	an/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, ou	utcome of problem		Ectopic p	eanancy						ate of deliv		
5	the dea by the at ached fo	hysici	in the past 12 months? 1 ☐ Yes 2 ĀNo 9 ☐ Unknown	4□Preg 9□Unkr	nant at time nown		Other (sp					_	M	onth	Day Year	
cords, r	The law requires that the death certificate be executed are hes been signed by the attending physicien and page 2 should be detached for use as the burial-transit	à	Part II. Dther significant conditions Stroke	contributing to o	death but not	t resulting in the u	nderlying o	ause give	n in Part I.					itribute to	the cause of death?	- 1
lo a	law req les beer 2 shou	Completed	Hypertension									Was an	24b.	Were aut	opsy findings availa	able of
אוומו א	ificete ?	e Con	Pneumonia 25. Was case referred to medical						OS Diago	of Doort	1 ☐ Y			death?	2 🗆 No	
5	hysicia his cerl I direct	ToB	examiner? 1 ☐ Yes ※XXNo			2 ER/Outpatier			r: 4 XX Nu				e 6 🗆 Ot	her (Speci	fy)	
	nding P th. r: After t e funera	ation:	27. Manner of Death 1 ∰Natural 5 ☐ Pending 2 ☐ Accident investigat		of Injury oth, Day Yea	ar) 28b. Time o	M 2	8c. Injury Work 1 🗆 Y	at ? ′es 2 🔲	-	28d. Descr	ribe how	injury occu	rred		
DIVISION	or Atte after des Director in by th	Certification:	3 Suicide 6 Could not 4 Homicide determine	art 286. Plac	e of Injury - / ling, etc. (Sp	At home, farm, str pecify)	eet, factor	r, office				on (Street r Town, S		ber or Rur	al Route Number,	
	To the Nours also datending Physician: The law within 24 hours after death. To the Funerel Director: After this certificate hes completely filled in by the funeral director, page 2	edical C	(Check only 2 Medical Ex	Physician: To th aminer: On the b	e best of my	knowledge, deat	n occurred	at the tim	e, date an	d place, th occurr	and due to	the caus	e(s) and m	anner as	stated.	
	vithin 2 Fo the	Med	29b. Signature and title of certifier	and mar	ner stated.	<u> </u>		. License							Day, Year)	
	2		PRISA	•				I	28656			0	ctober	1, 20	07	
	SC		30. Name and address of person wh Ravi Passi MD			(Item 23a) (Type, 1e Silver (, Mary	land	209	10					
	Sta Registr		31. Date filed (Month, Day, Year) OCT 0 3 2007	Jan 32. 1	Registrar's S	ionature	-									

Physician /Medical Examiner Examiner

Physician

/Medical

Examiner

Director

Funeral

Completed by

Be

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatte event, the Medical Examiner must be notified at

Baltimore, Maryland 21215-0036

attending physician and for use as the burial-tran should be detached

n/Medical

the death certificate be executed

Division or Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director; p

ıysıcıaı	in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	1 ∐Live birth 2 ∏ Fetal death 4 ∏ Pregnant at time of death 9 ☐ Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)	Month Day Year
ed by Pr	Part II. Other significant conditions	contributing to death but not resulting in t	the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 √√2 Yes 2 □ No 3 □ Probably 4 □ Unknown
Complet				24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☑ No
o ne	25. Was case referred to medical examiner? 1 ☐ Yes 2▼ No	Hospital: 1 (XInpatient 2 ER/Outp	Other	n (Check only one) me 5 ☐ Residence 6 ☐ Other (Specify)
ation: I	27. Manner of Death 1 Natural 5 □ Pending 2 □ Accident investigation	28a. Date of Injury (Month, Day Year) 28b. Tir Injury		28d. Describe how injury occurred
eninc	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined		n, street, factory, office	 Location (Street and Number or Rural Route Number, City or Town, State)
a can				and due to the cause(s) and manner as stated.

Alan R. Segal, M.D.

29d. Date signed (Month, Day, Year) September 26, 2007 D52261

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

1500 Forest Glen Road Silver Spring,MD 20910

29c. License number

31. Date filed (Month, Day, Year) State

29b. Signature and title of certifier

OCT 0 3 2007 Registrar's Signature

Registrar

			For State Registrar	State of Marylar	•		of Health			ene 2 No 2 0	07	33403
			Decedent's Name (First, Middle, Last)						2. Date of Death		-	3. Time of Death
	Physicia	~	Joseph Vanze	~~					Month	Day	Year	0 00 M
1	/Medic Examin	_	4a. Facility Name (If not institution, give s.			4b. City, To	own, or Location		Septembe	4c. County		2:22 A
	LXamiii		TUT Millonnium of I	Powoatry 11 o		For	00+1111			Dwdw	oo Co	eorge's
-	Funeral		THI Millennium of F 5. Social Security Number 6. Sex		last birthday)	If Under 1		er 24 Hrs.	8. Date of Birth			lace (State or Foreign
	Director		217-14-7976	M 2□F 85	Yrs.	Months	Days Hours	1	(Month, Day, 1			
-			Usual Residence of Decedent						Sept. 6,	1922	Mary	yland
	ylan		10a. State 10b. County	10c. Ci	ty, Town or Lo	cation					1	0d. Inside City Limits
	death with the Maryland ma 23a or 28a-f show r must be notified at	ţ	District of Colum	nbia	Wash	ington						1 Q Yes 2 □ No
	r 28	Director	10e. Street and Number			10f. Zip C	Code		10	g. Citizen of	What Coun	itry?
	3a o	9	1823 Independence	Avenue SF		200	03			United	Stat	-60
	deat ma	Funeral		2. Was Decedent Ever in L	J.S. 13.			Origin? (Spe	crfy Yes or No- Rican, etc.)	14. Rad	e - Americ	an Indian,
٥	or its		1 Never Married 2 Married	Armed Forces? 1 ☐Yes 2 ☐ No					Hican, etc.)		ck, White, Af 1	etc. cican
3	al', o	þ	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2[No Specia	fy:		Specif	y: .	rican
ק י	be filed within 72 hours after death with the Marylan hall Hygiene. At other then "natural; or itema 23a or 28a-f show event, the Modical Exeminar must be notified at	Completed	15. Decedent's Educ		16a. Deced	dent's Usual	Occupation		10	6b. Kind of B		
312-0036	Mar 7	ple	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	life. I	DO NOT use	done during m retired)	ost of worki	ng			
7	d wit	E O	12 years	Concess (1 40/01/		Black	smith			Self E	mp1ox	zed
<u> </u>	otha ant,	Bec	17. Father's Name (First, Middle, Last)					ther's Name	(First, Middle, Ma			
land	should be to the total in the t	10 B	Preston Vanzego					Emma	Washingt	on		
<u>_</u>	2 should and N is man		19a. Informant's Name/Relationship (Typ	pe, Print)	19b. Mailir	ng Address (l Route Number,		State, Zip	Code)
Z Z	27 is		Bertha Vanzego - W	life	1823	Indepe	ndence	Ave.,	SE Wash	ingtor	DC	20003
စ် ု	es 1 and 2 should b of Health and Ment f Item 27 is markad r other traumatic e		20a. Method of Disposition		Place of Dispo					c. Location	-	
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altimore,	it. P		21. Sign ture of Financial Service Disease						, 2007_			
g	Depa Impo any ir		Selection of the select	TO STORY AT					wart Fu			
-			San Allen	Clinto V					NE Washir		DC 2	
			23a. Part i Enter the disease, or complice shock, or heart failure. List only on	e cause on each line.	tn. Do not ent	er the mode	or aying, such a	as cardiac d	r respiratory arres	it,		Approximate Interval Between Onset and Death
F	Physician		Immediate Cause (Final disease or condition	Pneumonia								Oriset and Death
	/Medical Examiner		resulting in death)	Due to (or as a conse	quence of):							
	CXAIIIIIIEI		Sequentially list conditions, b.	Respirator		ure						
	D =	nei	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Dua to (or as a conse								
	nd nd trans	Examine	Cause (Disease or injury that initiated events c.	Chronic Ob		ive Pu	lmonary	Dise	ase			
Ď,	e exe	Š	resulting in death) Last	Due to (or as a conse	quence of):							
8/60	certificate be executed ding physicien and use as the burial-transit	dlcal	d									
٥	ng pl		IF FEMALE:							1	- 1	
Š R	eath certific ettending p for use as	clan/Me	23b. Was decedent pregnant 23	3c. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Fet		Ectopic pre	nnancy				te of delive	•
	death	SICI	in the past 12 months? 1 \(\subseteq \text{Yes} 2 \subseteq \text{No} \)	4 Pregnant at time of 9 Unknown		Other (spec				Me	onth	Day Year
J.	at the by th tache	Physi	9 Unknown	3LI OTIKITOWIT								
<u>'</u>	w requires that the dibean signed by the should be detached	by F	Part II. Other significant conditions con	tributing to death but not re	sulting in the u	nderlying cau	use given in Pai	rt I.	23e. Did toba	cco use con	tribute to th	ne cause of death?
2	quire an sig								1 ☐ Yes	20 No	3 Prob	ably 4 Unknown
Hecord	law re es bec 2 sho	Set							24a. Was an	24b.	Were auto	psy findings available
ř	0 5 0	Completed							autopsy perform	ed?	prior to cor death?	mpletion of cause of
	ilcian: Th certificete rector, pag	ပိ	25. Was case referred to medical				ac Di-	and Dooth	1 Yes 2	25.	1 🗌 Yes	2 No
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	Phya or this oral di	-	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of		c. Injury at Work?		ne 5 Resider 28d. Describe hov			y)
5	ding th.	후	1 ⊊Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury	м	Work? 1 ☐ Yes 2					
DIVISION	of or Attending after deeth. I Diractor: After din by the fune	Certification	3 Suicide 6 Could not be	28e. Place of Injury - At I	nome, farm, str	eet, factory.	office		28f. Location (Stre	et and Num	ber or Rura	V Route Number.
_		ert	4 Homicide	building, etc. (Spec	ify)	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			City or Town,			
	Hospital or 24 hours afte Funeral Dir letely filled in		29a. Certifier 1 X Certifying Phys	ician: To the best of my kn	owledge deat	h occurred at	the time date	and place	and due to the car	isa(s) and m	anner as c	taled
	24 h Fur etely	Medical		er: On the basis of examin and manner stated.	ation and/or in	vestigation, i	n my opinion, d	death occurr	ed at the time, dat	e and place,	and due to	the cause(s)
	To the h within 2 To the I complet	Me	29b. Signature and title of certifier			29c.	License numbe	ər	29	d. Date signe	ed (Month.	Day, Year)
	⊢ ≱ ⊢ ŏ	90A	* Harris	\sim						-		
)			, 6,100-000	U			51520			septer	noer 2	29, 2007
	(5)		30. Name and address of person who co				hingto-	DC.	20032			
			Bahram Pishdad, M 31. Date filed (Month, Day, Year)			- was	HTHELOI	טע פּיַ	20032			
	Sta Registr		OCT 0 1 2007 /	32. Registrar's Sign	ul							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 2007 33414 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** Month 10:10a lease 2007 /Medical 4c. County of Death Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner If Under 1 Year | If Under 24 Hrs | Months | Days | Hours | Min. 6. Sex inces 9. Birthplace (State or Fereign Country) Hospita 7. Age (In yrs. last birthday) 5. Social Security Number 8. Date of Birth (Month, Day) **Funeral** 1 M 2 KF 38 383 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 17 is marked other than "natural; or Items 23a or 28a-f show treumatic event, the Medical Examiner must be notified at the countries. 1 Yes 2 No by Funeral Director MD District rince George 10e. Street and Number 10g. Citizen of What Country? Koacl SA 1624 son 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 Yes 2 No Specify: Black. 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 115. Itandler 405 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be . Peges 1 and 2 should be fil ment of Health and Mental H tant: If Itam 27 Is marked ott Sprigner 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)4/3203 19a. Informant's me/Rela ionship e, Print) , mc Caney -Daughter 166 Ed 1667 EastLong Columbus, Ohio or other 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) permit. Pege Department o Important: If any injury or once. 200 shington Nat 21. Signature of Funeral Service Licensee Name and Address of Facility OHN T. RHINES 12th STNE WASH DC Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dus to (Sr as a consequence of) Examiner ed by the attending physicien and detached for use as the burial-transit Due to (or as a consequence of): Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 No
9 ☐ Unknown Day Month Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 TYes 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has this certificate 1 Yes 2 No the funeral director, 25. Was case referred to medical examiner? 26. Place of Death | Check only one Hospital: Other: 1 ☐ Yes 2 No 1 Inpatient 2 K ER/Outpatient 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification; To 3 DOA 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After (1 Natural 2 Accident 5 Pending 1 TYes 2 □No investigation 3 🗌 Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital within 24 hours a To the Funerel C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signature and little of certifier

State Registrar

or Attending Physicien: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

with the Maryland

filed within 72 hours after death

Baltimore, Maryland 21215-0036

DHMH 17 Rev 1/2001

0

31. Date filed (Month, Day,

Year)

2007

32. Registrar's Signature

and address of person who completed cause of death (Iteg 23a) (Type, Print)

HOT Sh Harian 3001 Hisphal Dr Cheverly mb 20785

Tiled (Month Day Year)

23 Decimal Character of the person

State of Maryland / Department of Health and Mental Hygiene

33405

Like .	Physiciar /Medica Examine
	Funeral Director

			1- State Registrar	ertificate of Death		eg. No.	33405
	Dhysisi		1. Decedent's Name (First, Middle, Last)		2. Date of Dea Month	th Day Year	3. Time of Death
	Physicia /Medic		GERTRUDE C. WOLFE		SEPT.	29 2007	4:50AM [™]
1	Examin	er	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of De	eath	4c. County of Deat	
	and a state of the state of the		1175 S. WASHINGTON ST., UNIT 18 5. Social Security Number 6. Sex 7. Age (In yrs. last birthda	EASTON V) If Under 1 Year If Under 24 H	lm 0 D-1 (D'-4)	TALBO'	
į,	Funeral Director		061-03-9721 1□ M 2XF 89 Yrs.		in. 8. Date of Birth (Month, Day SEPT 1	Year Olo Co	hplace (State or Foreign untry) W YORK
	and w		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or	Location			10d. Inside City Limits
	Marylan f show ied at	힏	MD TALBOT EA	STON			Maryes 2 □ No
	the 28a	rec	10e. Street and Number	10f. Zip Code	1	0g. Citizen of What Co	Luntry?
	h with	Funeral Director	1175 S. WASHINGTON ST., UNIT 18	21601		USA	
	deat	ner	11. Marital Status 12. Was Decedent Ever in U.S. 1 Armed Forces?	B. Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pu	(Specify Yes or No-	14. Race - Ame Black, Whit	
215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 📉 No If Yes, Give Year or Dates:	1 ☐ Yes 2X No Specify:	one moun, etc.,	Smaritu	ITE
2-0	72 hc natur lical	eted	15. Decedent's Education 16a. De (Specify only highest grade completed) (Gi	cedent's Usual Occupation	vorkina i	16b. Kind of Business/	Industry
2	nthin ne. han "	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	ve kind of work done during most of to DO NOT use retired)	9	OLDI IIO	MT
121	12 should be filed w n and Mental Hygie is marked other ti raumatic event, th		12 0 F	OMEMAKER 18. Methods 6	lame (First, Middle,	OWN HO	ME
Maryland	t be find the ded of	Be					
Ž	hould Me mark	ပ္	JOSEPH CANNIZZARO 19a. Informant's Name/Relationship (Type. Print) 19b. Ma	iling Address (Street and Number or	ITA BOGNET		Zin Code)
Ma	and 2 sealth ar n 27 is ier trau			1 WOODLAND CIRCL			
ē,	s 1 ar f Hea item 3		20a, Method of Disposition 20b. Place of Dis	position (Name of rematory or other place)	Date	20c. Location - City or	Town, State
E O	Pages nent of I int: If ite		1 LABurial 2 Gremation 3 Hemoval from State	i	/4/2007	OXFORD, MA	RYI.AND
Baltimore,	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Licensee	22. Name and Address of Facility FELLOWS, HELFENB	ETM C MELIN	IAM EINEDAI	HOME DA
Ö	Depa Impo any i		JUHA R MERIERON	200 S. HARRISON	ST EASTON,	MD 21601	HOME PA
			23a. Part1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line.	enter the mode of dying, such as care	diac or respiratory arr	rest,	Approximate Interval Between
-	Physician	7 0	Immediate Cause (Final disease or condition	Carcinon	~		Onset and Death
1	/Medical Examiner		resulting in death) Due to (or as a consequence of):				1 4 171011111
М	ZXdiffiller	_	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):				
	ted Isit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury				
	al-tran	xan	that initiated events ' c				
68760,	tificate be executed g physician and as the burial-transit		L _d				
	tificat g phy as the	ledical	, , , , , , , , , , , , , , , , , , ,				
Box	h cer endin use		IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal death	B□Ectopic pregnancy		23d. Date of de	,
	The law requires that the death cer ate has been signed by the attendin bage 2 should be detached for use	Physician/⊪		Other (specify)		Month	Day Year
P.0	hat th d by t letach	Phy	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I	23e Did to	bacco use contribute to	the cause of death?
Records,	signe d be c	by	Tarris Strot Significant Scholars Continuating to Scalar Barrior Issuining in the	andonying dadde given in rait i.	1/200		robably 4 Unknown
Ö	w requires to been signed should be	Completed			24a. Was a		
Rec	slcian : The law certificate has to irector, page 2 s	ם			autop	sy prior to death?	utopsy findings available completion of cause of
Vital			25. Was case referred to medical	26 Place et l	1 Yes Death (Check only or	2 No 1 Yes	2 □ No
>	Physician: The this certificate har director, page	To Be	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpai	Othor		ence 6 □Other (Spe	cify)
Or	ding Phy n. After thi funeral (ı.T	27. Manner of Death 28a. Date of Injury 28b. Time	of 28c. Injury at		ow injury occurred	Unity)
Ö	Attending r death. ector: After by the fune	atio	2 Accident investigation	M 1 ☐ Yes 2 ☐ No			
Division	r Atte	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, building, etc. (Specify)	street, factory, office	28f. Location (S City or Tow	treet and Number or R n, State)	ural Route Number,
	irs af		<u> </u>				
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, de 2 ☐ Medical Examiner: On the basis of examination and/o and manner stated.				
	Го th within Го th сощр	Me	29b. Signature and title of certifier	29c. License number	2	29d. Date signed (Mon	th, Day, Year)
			Mrs & MI Small	74723	, _	10/2/	2007
			30. Name and address of person who completed cause of death (Item 23a) (Type			1 /2	~~~
			MARY S. DESHIELDS, M.D. 401 COMME	RCE ST. SUITE 10	l, EASTON,	MD 21601	
	Sta Registr		31. Date filed (Month, Day, Year) OCT 0 3 2007	lasti .			

1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year SEPTEMBER 30 2007 **Physician** WALTER MORRIS WARD 2:30AM M /Medical 4a. Facility Name (II not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** CALVERT MEMORIAL HOSPITAL CALVERT PRINCE FREDERICK 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) MAY 25 1924 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral ¼** M 2□ F Days Hours Director 217-14-2286 83 MARYLAND Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If Item 27 is marked other than "natural", or items 23a or 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f shov notified at 1 XYes 2 No Director BALTIMORE CATONSVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ural", or items 23a or Examiner must be 303 MAIDEN CHOICE LANE 21228 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. i **X**Yes 2 ☐ No f Yes, Give 1 □ Never Married 2 □ Married If Yes, Give Year or Dates: 1 ☐ Yes 2 ☐ No Specify: Specify: <u>}</u> WHITE 3X Widowed 4 ☐ Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 PRINTER MEDICAL JOURNALS 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 GEORGE J. WARD MARY HIXENBAUGH 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5140 WESTLAND BLVD., BALTIMORE, MD 21227 BRENDA A. COYNE/DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If Ite any Injury or ot 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State MD VETERANS CEMETERY 10/5/2007 4 ☐ Donation 5 ☐ Other (Specify) HURLOCK, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA 200 S. HARRISON ST., EASTON, MD 21601 JOHN R. MERCERON 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Cardiac **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Cardioviscular disease there scientic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy
1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 Bowel 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown page 2 should Completed Hypertensive. Cardio vascular disease 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performe 2 12 No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 2 ER/Outpatient 3 DOA 27. Mapmer of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D50653 Ceyor GYAN, C. SURANA ROAD PEALE MP. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) STVA Decule Church ton 31. Date filed (Month State Registrar

			State of Maryland / Department of Heal 1- State Registrar Certificate of Dea	Ith and Me ath	ental Hygier	^e 2007	33407
*	Dii-i	Ö	1. Decedent's Name (First, Middle, Last)	1	2. Date of Death	Day Year	3. Time of Death
a	Physici /Medic		Bonnie Mae Wright		October 1		9:22 ам
	Examin	er	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Loca		İ	lc. County of Death	
	Funeral			Inder 24 Hrs	Data of Disth	Montgome 9. Birthp	lace (State or Foreign
ы	Director		413-26-9143 1 N 2 XX 85 Yrs. Months Days Ho	ours Min.	Month, Day, Yea	1922 Ten	nessee
	w w		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location				0d. Inside City Limits
	Maryla f sho	io.	Maryland Montgomery Silver Spring				1 □Yes 🍇 🖔 No
	r 28a.	Director	10e. Street and Number 10f. Zip Code		10g. (Citizen of What Cour	ntry?
	23a o ust be		3126 Gracefield Road, BG203 20904		1	USA	
က	within 72 hours after death with the Maryland ene. than "natural", or Items 23a or 28a-f show he Medical Examiner must be notified at	Funeral	11. Marital Status 1 □ Never Married 1 □ Never Married 1 □ Never Married 1 □ Ves 2 □ No If Yes, Give 1 □ Yes 2 □ No Specify Cuban, Me of the control o		ify Yes or No- ican, etc.)	14. Race - Americ Black, White,	etc.
21215-0036	tural", c	ed by	15. Decedent's Education 16a. Decedent's Usual Occupation		16b.	Specify: Wh Kind of Business/In	ite
215	hin 72 e. an "ng Medic	Be Completed	(Specify only highest grade completed) (Give kind of work done during life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+)	g most of working	7		
	ed wit ygiene yer the t, the	Con	1 Admin. Assist				vernment_
and	Ibe fill ntal H ed oth	Be			First, Middle, Maid	en Surname)	
Maryland	should nd Me mark matic	ᅀ	James Edward Cooke 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and N	laggie Number or Rural		y or Town, State, Zir	Code)
	alth ar		Diane Green/Daughter 7003 Knightho				·
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importants: If item 27 is marked other than "natural", or Items 23a or 28a-f show are young to other traumatic event, the Medical Examiner must be notified at ance.		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) Gate of Heaven	Octob	or 6	Location - City or To	
Baltir	Department of months of the second of the se		21. Signature of Funeral Service Licensee Francis J. 500 Univers	Çollin	97 S S Funera	ilver Sp al Home	ring, MD Inc.
ì	202 60		23a. Part Lenter the disease, or complications that caused the death. Do not enter the mode of dying, suc			silversp	Approximate
	Physician [*]		shock, v r heart failure. List only one cause on each line.		, , , , , , , , , , , , , , , , , , , ,		Interval Between Onset and Death
	/Medical		disease or condition resulting in death) a. Coronary Artery Disease Due to (or as a consequence of):				1 Year
	Examiner		Sequentially list conditions, b.				
	ted nsit	nine	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events C			J.	
,	execu n and ial-tra	Examiner	that initiated events c				
68760,	cate be executed physician and the burial-transit	dical	d				
			IF FEMALE:				
Вох	law requires that the death certifi as been signed by the attending I 2 should be detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months?			23d. Date of delive Month	ery Day Year
o.	the de	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown				
ď.	ss that gned b	by Pi	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in	Part I.	23e. Did tobacc	o use contribute to t	ne cause of death?
ord	w require been sign	ted	Atrial Fibrillation		1 Yes	2 No 3 Prol	oably 4 Munknown
Records,	e + e	Completed			24a. Was an autopsy performed	prior to co death?	psy findings available mpletion of cause of
or Vital	i clan: Th certificate ector, pag	Be C	25. Was case referred to medical 26.	Place of Death	1□ Yes 2√ (Check only one)	No 1 □Yes	2 NO
<u>></u>	S S =	To E		□ Nursing Hom	e 5 XX esidence	6 ☐Other (Specia	y)
o uc			27. Manner of Death 1 Natural 5 □ Pending (Month, Day Year) 2 □ Accident investigation 28a. Date of Injury 28b. Time of Injury 4 Work? 1 □ Yes	- 1	3d. Describe how in	jury occurred	
Division	death ctor: y the	ficat	3 Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office		3f. Location (Street	and Number or Run	al Route Number,
ă	s after al Dire	Certification:	4 ☐ Homicide determined building, etc. (Specify)		City or Town, St.	ate)	
	To the Hospital or A within 24 hours after To the Funeral Directorpletely filled in by	edical (29a. Certifier (Check only one) 1X Certifying Physician: To the best of my knowledge, death occurred at the time, de 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion and manner stated.				
	To the within To the comp	Me	29b. Signature and title of entifier 29c. License num			Date signed (Month,	
)	7		Mulllung D24093	ა	Oct	ober 2,	2007
			30. Name and address of person who completed cause of death (Item 23a) (Type, Print)				
	Sta	te	Mark Parkhurst, MD 3110 Gracefield Road, 31. Date filed (Month, Day, Year) 32. Redistrar's Signature	Silver	Spring	, MD 209	004
ď	Registr		OCT 0'3 2007 Seem St. Sante				

DHMH 17 Rev 1/2001

DHMH 17 Rev 1/2001

Registrar

OCT 1 1 2007

DONALD

Physician /Medical Examiner

attending physician and for use as the burial-transit signed by the a peen page 2 s has certificate director, s after death.

I Director: After this
of in by the funeral d

The law requires that the death certificate be executed

To the Hospital or Attending Physician:

within 24 hours at To the Funeral C completely filled pelli

Division or Vital Records, P.O. Box 68760,

22. Name and Address of Facility Framptom Funeral Home, P.A. 21. Signature of Funeral Service Licenses 216 N. Main St., Federalsburg, MD 21632 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Lisease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 □Ectopic pregnancy Month Day Year in the past 12 months? 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an Was an autopsy performed?
Yes 2 No 1∏ Yes 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1'⊊Yes 2 No £ 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death Certification: (Month, Day Year) Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3□ Suicide determined 4 Homicide Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) manner stated. 29d. Date signed (Month, Day, Year) Me of certifier 29b. Signature and

10d. Inside City Limits

1XIYes 2 No

State Registrar

DHMH 17 Rev 1/2001

levele

31. Date filed (Month, Day, Year)

ORIGINAL

Buchdons Pt. Rd. Ox conp. mp 21654

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Kopro

OCT 1 1

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32 Registrar's Signature

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DHMH 17 Rev 1/2001

			For	State of Maryland / Depa	irtment of Health	h and Mental Hy	giene	
		•	1 - State Registrar	Cer	tificate of Deat	th	Reg. No. 2007	33411
e i			1. Decedent's Name (First, Middle, Last)			2. Date of De	eath Day Year	3. Time of Death
	Physicia /Medic	246	Joseph Eugene W	lilkinson			25, 2007	2:40 p.m. ^M
	Examin	4,630	4a. Facility Name (If not institution, give s		4b. City, Town, or Location		4c. County of Deat	h
			Renaissance Garder	ns at Riderwood	Silver Spr:		Prince Ge	eorge's
	Funeral		5. Social Security Number 6. Sex		If Under 1 Year If Und Months Days Hour	der 24 Hrs. 8. Date of Bir rs Min. (Month, Da	rth 9. Birt	hplace (State or Foreign untry)
	Director		213-16-9269	M 2 F 86 Yrs.		April		yland
	and W		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Loc	cation			10d. Inside City Limits
	sho sho	ò	Maryland Prince Ge	eorge's Silver S	oring			1 ∐Yes 2 X No
	the N	Director	10e. Street and Number	0	10f. Zip Code		10g. Citizen of What Co	untry?
3	a or		3160 Gracefield Ro	nad Ant 2128	20904		U.S.A.	
	eath	Funeral		12. Was Decedent Ever in U.S. 13. V	Was Decedent of Hispanic	Origin? (Specify Yes or No	0- 14. Race - Ame	
	ter d riten iner	F	1 Never Married 2 Married	1MYes 2□No Army/	f Yes, specify Cuban, Mex		Black, Whit	e, etc.
3	ırs al	by	3 X Widowed 4 Divorced	If Yes, Give Airforce Year or Dates: WWII	1 □ Yes 2 X No Spec	cify:	Specify: W	nite
5	2 hou	ted	15. Decedent's Edu	cation 16a, Deced	dent's Usual Occupation kind of work done during r	most of working	16b. Kind of Business	Industry
2 1	Media 7	ple	(Specify only highest grade	College (1-4or 5+)	DO NOT use retired)	nost of working	University	of Mary Land
7	d with	Completed			ountant			Of rary failu
2	be filed within 72 hours after death with the Maryland tall Hygiene. d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Be C	17. Father's Name (First, Middle, Last)	•		other's Name (First, Middle		
2	Ment Ment arked atic e	10	William J. Will			Ethel Robins		
0	2 sho and is ma auma		19a. Informant's Name/Relationship (Ty		•	imber or Rural Route Numi	-	
	and and not be alth not tree tr	1.3	William Kevin Wilkinso			Court, Sunnyval	e, California 20c. Location - City or	
5	of H		20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ F		esition (Name of matory or other place)		1	
	Рад ment ant: uny о	11 8	4 □ Donation 5 □ Other (Specify)	-	en Crematory	9/28/2007	Alexandria	, Virginia
Dal	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Informatic file fine 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Licens	- 01 / 1 :	2. Name and Address of Fa	Gasch's in the control of the contro	Funeral Home	
			23a. Part1. Enter the disease, or compl	ications that caused the death. Do not ent ne cause on each line.	er the mode of dying, such	h as cardiac or respiratory	arrest,	Approximate Interval Between
٠,	Physician i	Ø G	Immediate Cause (Final					Onset and Death
¢.	/Medical		disease or condition resulting in death)	a. Cachexia Due to (or as a consequence of):				4 weeks
	Examiner			Esophageal Stric	ture			6 weeks
		Je.	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequence of):				
	cuted nd ransit	Examiner	cause. Eriter Underlying Cause (Disease or injury that initiated events	D,				
Ď	an ar rial-tı		resulting in death) Last	Due to (or as a consequence of):				
0/00,	cate be executed physician and the burial-transit	dical		d				
Ö	rtifica ng ph as tl	Med	IF FEMALE:					-
200	ath ce tendi	an/	23b. Was decedent pregnant in the past 12 months?		Ectopic pregnancy		23d. Date of de Month	livery Day Year
	e des he at red fo	sici	1 □ Yes 2 □ No 9 □ Unknown	4□Pregnant at time of death 5 [9□Unknown	Other (specify)			
·	w requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	Physician/Me		ntributing to death but not resulting in the u	nderlying cause given in P	Part I. 23e, Did	I tobacco use contribute t	o the cause of death?
ń	res the	b	Pair II. Other significant conditions co	numbung to death but not resulting in the d	riderlying dadde given in			robably 4X Unknown
ecords	requi	Completed						
<u> </u>	The law ate has b	nple				24a. Wa	opsy prior to	utopsy findings available completion of cause of
	10 22	ខ្ល				1□ Yes		s 2□No
N I G	Physician: The law rthis certificate has t ral director, page 2 s	Be	25. Was case referred to medical examiner?	Hospital:		Place of Death Check onl		Assisted.
_	his ld	2	T Yes ZX XNO	1 Inpatient 2 EH/Outpatier	III 3LJ DOA 4L	Nursing Home 5 Re	sidence 6 XOther (Speed) show injury occurred	ecity iving Center
Ē	ding Physician: After this certific funeral director,	<u>=</u>	27. Manner of Death 1 X Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year) 28b. Time of Injury	Work?		e now injury occurred	
SION	ttend death ttor:	cat	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of injury - At home, farm, st			(Street and Number or F	Rural Route Number.
<u> </u>	or A	Certification:	4 Homicide determined	building, etc. (Specify)	icos, lactory, office	City or T	own, State)	
_	e Hospital or Attending P 24 hours after death. e Funeral Director: After t etely filled in by the funera		29a. Certifier 1 X Certifying Phy	sician: To the best of my knowledge, deat	th occurred at the time. da	ite and place, and due to th	ne cause(s) and manner a	as stated.
	Hos 24 hc Fun stefy	dical	(Check only 2 Medical Exam	iner: On the basis of examination and/or in and manner stated.	nvestigation, in my opinion	, death occurred at the time	e, date and place, and du	e to the cause(s)

State Registrar

31. Date filed (Month, Day, Year) OCT 0 1 2007

29b. Signature and title

Mark A. Parkhurst, M.D., 3110 Gracefield Road, Silver Spring, Maryland 20904 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

B93432

29d. Date signed (Month, Day, Year)

September 28, 2007

Registrar

OCME 2006

State

30. Name and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner

32. Registrar's Signature

Donna M. Vincenti, MD

31. Date filed (Month, Day, Year)

111 Penn Street, Baltimore, MD 21201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician Julia Anna Breitenbach October 14, 2007 12:30a /Medical 4b. City, Town, or Location of Death English Council 4a. Facility Name (If not institution, give street and number)
2745 Arbutus Avenue 4c. County of Death Baltimore Examiner 8. Date of Birth (Month, Day, Year If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country)
Maryland 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Days Hours 1 □ M 2 🗓 F May 20. 1919 88 Director 220-05-2187 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County "natural", or items 23a or 28a-f show idical Examiner must be notifled at 1 ☐ Yes 2 No MD Baltimore English Council Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U.S.A. 21227 2745 Arbutus Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Bace - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 ☐ Never Married 2 Married 1 ☐ Yes 2 X No white Specify Specify: ò 3 Widowed 4 Divorced Completed permit. Pages 1 and 2 should be filed within 72 hr. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical once. 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)
Executive Secretary 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Commercial Credit 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Elizabeth Moss John Jordan 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2745 Arbutus Avenue English Council, MD 21227 William Breitenbach/Son 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition Cedar Hill Cemetery 10-17-2007 Brooklyn, MD 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Ambrose Funeral Home of Lansdowne 2719 Hammonds Ferry Rd. Lansdowne MD 21227 Cope. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or s a consequence of): Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-tra Due to (or as a consequence of) physician Physician/Medical the for use as IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) the 9 Unknown 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ pe 1 | Yes 2 | No 3 | Probably 4 | Unknown Be Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an autopsy certificate 1∐ Yes Physician: 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 1 Inpatient Certification: To After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident 6 Could not be determined 3□ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

P.0. Division or Vital Records,

Baltimore, Maryland 21215-0036

Hospital or Attending 24 hours after death Funeral Director: filled in by within 24 hor To the Fune

State

Medical

Richard Walsh

OCT 1 8 2007

29b. Signature and title of certifier

29a. Certifier

(Check only one)

and manner stated.

29c. License number

ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year) 10/15/2007

30. Name an address of person who completed cause of death (Item 23a) (Type, Print)

4660 31. Date filed (Month, Day, Year)

Baltimore 32. Registrar's Signature

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** OCTOBER Layton O. Burris 2,200 /Medical 4a. Facility Name (If not institution, 4b. City, Town, or Location of Death give street and number 4c. County of Death Examiner SAINI HUNES DITAL ALTIMOR N/A 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Min. 1**X** M 2□ F 5, 1916 Director 277-05-1587 91 Feb. Óhio Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits "natural", or items 23a or 28a-f show edical Examiner must be notified at 1 ☐ Yes 2 X No Director Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6604 Rannoch Drive 21228 United States by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Y Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White 3 ☑ Widowed 4 □ Divorced Completed permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medic al 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College 41-4or 5+) <u>Management</u> Steel 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Emmett Seaton Burris Flora Regina Bishop 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 159 Garden Ridge Rd., Baltimore, MD 21228 Richard Burris - Son 20b. Place of Disposition (Name of Acametery, crematory or other place)
Arlington
National Cemetery Date 20c. Location - City or Town, State Method of Disposition Burial 2 ☐ Cremation 3 ☐Removal from State nation 5 ☐ Other (Specify) 1-7-2008 Arlington, VA 22. Name and Address of Facility Ambrose Funeral Home, Inc. 1328 Sulphur Spring Rd., Arbutus, MD 21227 23a. Part1. Enter the disease, or complications that can sed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** SEPTIC SHOCK 6 hours /Medical Due to (or as a consequence of) Examiner Syears APLASTIC ANDMIN Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of) $\beta uRRIS$ LAYTON Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical the as 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant ned by the atten edetached for u 3 Ectopic pregnancy in the past 12 months? Day Month Year 4 ☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 TYes 2 No 3 Probably 4 ☐Unknown CORONARY ARTERY DISEASE Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an OBSTRUCTIVE PULMONARY DISEASE CHRONIC page 2 certificate 1□ Yes 2☐No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No မ 1 Inpatient 2☐ER/Outpatient 3☐ DOA within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral 27. Manner eath 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred Hospital or Attending 1 atural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 v ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. N m and address of person who ampleted cause of death (Item 23a) (Type, Print) D2264F OCTOBER 12, 2007

State Registrar 31. Date flod "

filed (Month, Day, Year)

7. SHYDER, MID

8 2007

32. Registrar's Signature

900 SOUTH CATON AVENUE BALTIMORE MARYLAND

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Harley Brady OCTOBER 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Baltimore Washington Medical Center Glen Burnie 8. Date of Birth (Month, Day, Year)
May 03 1920 If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1⊠M 2□F 415-07-3404 Director Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f show Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Maryland Anne Arundel Severn 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 516 Pasture Brook Road 21144 USA within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Stationary Engineer Distillery permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygic Important: If Item 27 Is marked other i any Injury or other traumatic event, th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Shirley Brady Nancy Barker 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Betty Brady (spouse) 516 Pasture Brook Road, Severn, MD 21144 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cedar Hill Cemetery Baltimore, Maryland 2007 22. Name and Address of Facility Stallings Funeral Home, P.A 21. Signatur of Funeral Service Licensee 3111 Mountain Road, Pasadena, MD 21122 r caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, each line. 23a. Part1. Enter the disease, or compli ations the shock, or heart failure. List only or e c use of Immediate Cause (Final disease or condition resulting in death)) ROSEPSIS Physician DAYS /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Unisease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physician and for use as the burial-transit Due to (or as a consequence of) $\begin{array}{ccc} & \mathcal{I}\mathcal{A}\mathcal{A}\mathcal{L}\mathcal{E} & \mathcal{L}\mathcal{A}\mathcal{A}\mathcal{D}\mathcal{A} \\ \text{Division or Vital Records, P.O. Box 68760,} \end{array}$ Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 □Live birth 2 □ Fetal death 4 □ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) To the Hospital or Attending Physician: The law requires that the de within 24 hours after death.

When the Funeral Director: After this certificate has been signed by the a completely filled in by the funeral director, page 2 should be detached. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ◯XNo 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 2 No 1∐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 🔀 înpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 1 No 2 ER/Outpatient 3 DOA 2 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation (Month, Day Year) Injury 1 Natural 1 ∏Yes 2 ∏No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier Scertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 1006121

12

State Registrar 31. Date filed (Month, Day, Year)

OCT 1 8 2007

TARVINDEY

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



BWMC HOSPITAL, GLENBURNIE MD 2106

Bryant

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:

College (1-4or 5+)

7. Age (In vrs. last birthday)

56

10c. City, Town or Location

1. Decedent's Name (First, Middle, Last)

Yvonne

6 Sex

Anne Arundel

15. Decedent's Education (Specify only highest grade completed)

1 ☐ M 2 💢 F

4a. Facility Name (If not institution, give street and number)

10b. County

Sharon

5. Social Security Number

216-54-5115

10a. State

Maryland

11. Marital Status

10e. Street and Number

Director

Funeral

þ

Completed

Usual Residence of Decedent

208 Oak Drive

208 Oak Drive

1 Never Married 2 Married

3 ☐ Widowed 4 ☑ Divorced

Elementary/Secondary (0-12)

17. Father's Name (First, Middle, Last)

Physician

/Medical

Examiner

Funeral

Director

Certificate of Death

4b. City, Town, or Location of Death

If Under 1 Year If Under 24 Hrs.

Months Days Hours Min.

Days

10f. Zip Code

1 ☐ Yes 2 ☑ No

16a Decedent's Usual Occupation

Pasadena

Pasadena

21122

Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

Specify:

(Give kind of work done during most of working life. DO NOT use retired)

Secretary

Ď O	Joseph C. Ma	guire Sr.	Ruth May	Tuder								
- [19a. Informant's Name/Relationship (7	~	19b. Mailing Address (Street	and Number or Rural R	oute Number, City	or Town, State, .	Zip Code)					
	Ronald J. Bryant	(son)	6-Zammer Cour	t, Palm Coas	st, FL 3	2164						
	20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Hemovai irom State	Place of Disposition (Name of cemetery, crematory or other place adowridge Cemet	erv 2007	Fik	Location - City or ridge, N	Marvland					
	21. Signature of Funeral Service Licen	taller a	22. Name and Addres	ess of Facility Stal tain Road,	lings Fu	neral Ho	ome, P.A.					
	23a. Part1 Enter the disease, or complications that caused the de th. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betwee Onset and Onset a											
	Immediate Cause (Final disease or condition resulting in death)	a. OVARIA Due to (or as a conse	N CANCE				6 Monnt					
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	ause. Ener Underlying ause (Disease or injury										
al Examine	that initiated events resulting in death) Last C. Due to (or as a consequence of):											
Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ■ No 9 □ Unknown 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 5 □ Other (specify) Month 23d. Date of delive time of death 5 □ Other (specify)											
2	Part II. Other significant conditions of	ontributing to death but not re	esulting in the underlying cause given	ven in Part I.	23e. Did tobacco		o the cause of death					
Completed					24a. Was an autopsy performed? 1 Yes 2 ■1	death?	utopsy findings avai completion of cause s 2 □ No					
De C	25. Was case referred to medical			26. Place of Death (C								
0	examiner? 1 ☐ Yes 2 ii No	Hospital: 1 ☐ Inpatient 2	□ ER/Outpatient 3 □ DOA Oth	ner: 4 Nursing Home	5 Residence	6 □Other (Spe	ecify)					
	27. Manner of Death 1 ■ Natural 5 □ Pending 2 □ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of lnjury	ry at 28d rk?] Yes 2 □ No	. Describe how in	jury occurred						
Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - At building, etc. (Spec	and Number or F ate)	lural Route Number,								
Medical C			nowledge, death occurred at the t nation and/or investigation, in my									
ĕ	29b. Signature and title of certifier	_	29c. Licens			Date signed (Mon						
	1 moli AT	Mr. M	(i) 0	43934 - PAUL 1		10/16	107					
	30. Name and add es of person who	completed cause of death (It	em 23a) (Type, Print)									

Registrar's Signature

33416 2. Date of Death 14 2007 3:30 PM 4c. County of Death

Birthplace (State or Foreign Country)

MD

10d. Inside City Limits

1 ☐ Yes 2 🔀 No

Anne Arundel

October 0

Nov.

18. Mother's Name (First, Middle, Maiden Surname)

8. Date of Birth (Month, Day, Year)

29

1950

10g. Citizen of What Country?

Specify:

16b. Kind of Business/Industry

Medical

2 No 3 Probably 4 Unknown

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

USA

Black, White, etc.

14 Race - American Indian,

White

within 2

State Registrar

31. Date filed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene 2007 33417 1 - For State Registra Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 17, 2007 Oliver Cromwell Bayne, October Sr. 1:25 A /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Fecility Name (If not institution, give street and number) Examiner Taneytown Carroll County Lorien Nursing Center If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral X**▼ M 2□ F 89 Yrs 215-10-5232 4-20-1918 Director Maryland Usual Residence of Decedent with the Maryland 10a. State 10d. Inside City Limits 10b. County 10c. City, Town or Location ir than "natural", or iteme 23a or 28a-f ehow the Medical Examiner must be notified at 1 ☐ Yes 🎗 🔀 No Maryland Director Carroll County Westminster 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1952 Old Taneytown Road 21158 USA Funeral 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 11. Marital Status filed within 72 hours after 1 ☐ Yes ★★ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 🏋 No Specify: Specify: þ white XXWidowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Maryland Steel Pages 1 and 2 should be filed within nent of Health and Mental Hygiene int: if item 27 is marked other than ' College (1-4or 5+) Elementary/Secondary (0-12) Products Company Welder 12 other traumatic event. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be George Bayne Estella Baggerly 19a. Informant's Name/Relationship (Type, Pnint) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Douglas M. Bayne, Sr. Son 1952 Old Taneytown Road Westminster, MD 21158 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages
Department of I
Important: If It
eny injury or o 1 № Burial 2 Cremation 3 Removal from State Lorraine Park Cemetery 10/19/07 Woodlawn, Maryland 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility
Burgee-Henss-Seitz Funeral Home, Inc. 21. Signat us of Funeral Service 3631 Falls Road Baltimore, Maryland 21211 Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final evebro Vasculor Physician month disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed burial-transit ate hes been signed by the attending physician and page 2 should be detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760, by Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) 4 Pregnant at time of death Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 2 3 No 2E No 1 Yes funeral director, Be 25. Was case referred to medical 26. Place of Death | Check only one examiner Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3□ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c, Injury at Work? 28d. Describe how injury occurred After 1 Natural after death. 1 ☐ Yes 2 ☐ No 2 Accident investigation the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours a To the Funerel D Hospitel 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only the 29b. Signature and title of certifier October 17 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BINU CHACKO Stoner theme 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** 20 A M 10 07 16 DALLAS LEROY BENNETT /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore FRANKLIN SQUARE HOSPITAL CENTER Rosedale 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days 1 M 2 □ F Director 112-30-5446 66 Pennsylvania 25, 1941 Usual Residence of Decedent 10a. State 10c, City, Town or Location 10b. County 10d. Inside City Limits or 28a-f show "natural", or Items 23a or 28a-f shov edical Examiner must be notified at Director 1 ☐ Yes 2 No Maryland Harford Aberdeen 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours atter death with nent of Health and Mental Hygiene. 64 Valley Bottom Road 21001 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 □XYes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 🏂 No Specify. þ Specify. 3 ☐ Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Bennett, Dallas (Give kind of work done during most of working life. DO NOT use retired) than, Elementary/Secondary (0-12) College (1-4or 5+) Roads & Bridges Construction Worker 12 permit. Pages 1 and 2 should be filed Department of Health and Mental Hygi Important: If item 27 is marked other any injury or other traumatic event, ti 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be မှ Arthur (unk) Bennett <u>Hermene</u> (unk) Burd 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ethel Ann Bennett / Wife 64 Valley Bottom Road, Aberdeen, Maryland 21001 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hilltop Service Corp. 10-18-07 Towson, Maryland 21. Signature of Funeral Service Ocensee ²²MCCOMAS Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 rt1. Enter the disease, or com cati shock, or heart failure. List only ne c at caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) Sepsis /Medical Due to (or as a consequence of): Examiner Metastatic Lung Cancer Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 ☐Live birth 3 □Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed? 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient မှ 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No s after death.

I Director: A

of in by the fu 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours aft

To the Funeral Di

completely filled in 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) the

31. Date filed (Month, Day, Year) State OCT18 Registrar

29b. Signature ar

title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



MYLLADET

DHMH 17 Rev 1/2001

29c. License number

D0064755

BALTIMORE

29d. Date signed (Month, Day, Year)

21237

			1 - For State Registrar	State	of Marylar	nd / Depa <i>Cei</i>	artment or <i>rtificate</i>	of Health of Deat	n and I th	Mental Hyg	gienez Reg. No.	007	33420
ı	Dhysisi	ion	1. Decedent's Name (First, Midd	e, Last)						2. Date of Dea	ath Day	Year	3. Time of Death
	Physici /Medio		LYNN HERBEF							OCTOBER	,	2007	9:30 P M
	Examir	ner	4a. Facility Name (If not institutio				4b. City, To	wn, or Location	n of Death	1	4c. Co	ounty of Death	
			Bel Air Health 5. Social Security Number	& Rehabil			Bel If Under 1		ler 24 Hrs.	100		ford	
	Funeral Director		219-36-0224	1.XM 2□ F	7. Age (In yrs.	. <i>iast οιππα</i> α <i>γ)</i> Yrs.		ays Hours		8. Date of Birth (Month, Day	v, Year)	Cou	
		1	Usual Residence of Decedent		88		<u> </u>			Dec. 31	, 191	8 Nort	n Carolina
	how how		10a. State 10b. County		10c. Ci	ity, Town or Lo	eation						10d. Inside City Limits
	h the Maryland r 28s-f show Localited at	ctor	Maryland Harfo	rd	Be	l Air							1 ☐ Yes 2 🗽No
	death with the Maryland me 23a or 28s-f show rmust be notified at	Director	10e. Street and Number				10f. Zip Co	ode			10g. Citizer	of What Cou	ntry?
	ath w		509 South Fou				210				USA		
		Funerai	11. Marital Status	Armed F			Was Deceder If Yes, specify	t of Hispanic (Cuban, Mexic	Origin? (S can, Puert	pecify Yes or No- o Rican, etc.)	14.	Race - Ameri Black, White,	
30	hours after death with tural; or iteme 23a or al Exeminer must be	by	1 ☐ Never Married 2 ☑ Mar 3 ☐ Widowed 4 ☐ Divorced	If Yes G	ive		1 ☐ Yes 218	No Speci	ity:		Sp	ecify:	nite
	natural,		15. Deceder	t's Education			dent's Usual (16b. Kind	of Business/In	
2	within 72 ene. than na	Completed	(Specify only higher Elementary/Secondary (0-12)	st grade completed) College ((Give	kind of work of DO NOT use	done during m etired)	ost of wor	king			,
Z	o o o	Con	12			Owner	:/Opera	tor			Dair	v Farme	er
2	d oth	Be	17. Father's Name (First, Middle,				_	18. Mo	ther's Nan	ne (First, Middle,	Maiden Su	mame)	
	should nd Men marke imatic	2	Clyde Walter			.,				nk) Coome			
	12 sh and reum reum	1 3	19a. Informant's Name/Relations			19b. Mailir	ng Address (S	treet and Nun	nber or Ru	ral Route Numbe	r, City or To	own, State, Zip	Code)
e) e	s 1 and 2 should be filed within 72 hr Heath and Mental Hygiene. Item 27 is marked other than "natu other treumatic event, the Madical		Lena Reedy Be 20a. Method of Disposition	edsaul /Wi	ife 20b (509_S	cuth F	cuntai	n Gre	en Rd, I		ion - City or To	
P	8 2 = 5		P Burial 2 ☐ Cremation		State	cemetery, crer	natory`or othe	r place)	1		20c. Locat	ion - City or 1	own, State
_	permit. Pag Departmen Important: any injury once.		4 □ Donation 5 □ Other (S		Be]	L Air M	emoria	1 Grdn	10-1	.7-07 I	Bel A	ir, Mar	ylard
מ	Departitue Departitue Import any inj		Alli. Ma	104 0	1	"	McComa	s Fune	rál E	iome, P.A	A		
Н			23a. Part1. Enter he tisease, o	complications that	aused the dea	Do not ent	er the mode of	f dyna, such	aș cardiac	or respiratory ari	nadon , rest,	. Marvi	and 21009 Approximate
	nysician		Immediate Cause (Final	only one cause on	each tine.	W a	1		/	_			Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	a Due to	for as a consec	uence of):	$\alpha($	1000	un	<u>e.</u>	7-		Luville
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1	p #	ner	Sequentiatly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to	(or as a consec	quence of):			•				
V	and and I-trans	Examine	that initiated events resulting in death) Last	C	(or as a consec								
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00	ficate be physicials the bur	edical		d					-				
×	nding p	N/A	tF FEMALE: 23b. Was decedent pregnant		tcome of pregna						23d	. Date of delive	arv
	death e atte od for	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐ Pregr	ointh 2 🗌 Feta nant at time of c		Ectopic pregi Other <i>(speci</i>					Month	Day Year
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	een s	ted	Jene	nta	ч					1 🗆 Y	es 2 N	lo 3 🗆 Prot	pably 4 Unknown
ָ טַ	nasb a 2 st	Completed	Dypol	groude	ç n					24a. Was a autop:	an 2	4b. Were auto	psy findings available mpletion of cause of
	cate f	S	' /	/						perfor 1 ☐ Yes	med?	death?	2 🗆 No
5	certifi ector	Be	25. Was case referred to medica examiner?	Hospitat						th (Check only or			
5 8	this ral dir	၉	1 ☐ Yes 2 No 27. Magner of Death	28a. Date	-	ER/Outpatien 28b. Time of			Nursing H	ome 5 Resid			y)
5	After fune	ţ	1 ANatural 5 ☐ Pendir	g (Mon	th, Day Year)	Injury	M 280.	tnjury at Work? 1 Yes: 2[¬No	28d. Describe h	ow intury of	ccurred	
2	deal deal sctor	fica	3 ☐ Suicide 6 ☐ Could	not be 300 Blees	of tnjury - At h	ome, farm, str				28f. Location (S	treet and N	umber or Rura	il Route Number.
5	s after	Certification;	4 Homicide determ	build	ing, etc. (Specil	(y)	,,,,			City or Tow			
	To the hours after death withing Physician: The law within 24 hours after death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2.		29a. Certifier (Check-only 2 Medical	g Physician: To the Examiner: On the b	best of my kno	owledge, death	occurred at t	he time, date	and place	and due to the c	ause(s) and	d manner as s	tated.
	the F the F the F	Medical	1216	and man	ner stated.	and and or in							
1	o T w co	2	29b Signature and title of certifie	/		2	29c. L	cense numbe	r 	7 2	29d. Date si	igned (Month,	Day, Year)
			00//10	2 70	FACT			14 59	06	C 1	1ct	open 1	16 (0)
	0		30. Name and a sess of erson	who completed caus	se of death (Item	п 23a) (Туре,	Print)	61	1//	51	a 1	11/17	
	Sta	te.	31. Date filed (Month, Day, Year)	7 70 32. F	(508) Registrar's Signa	7 497	249(lifer	-100	y Hdy	eme	- run	
	Registr		, , , , ,	8 2007	10 Sept 1 1	B. A	medic			/			

			For State Registrar	State of Maryland	l / Depa <i>Cei</i>	artment of H rtificate of L	ealth and M Death		jiene (007	33421
			1. Decedent's Name (First, Middle, Las	t)				2. Date of Dea		Vaar	3. Time of Death
	Physici /Medio		Davon Br	OWO				Month O	Day 25	2007	1854 M
1	Examin		4a. Facility Name (If not institution, give			4b. City, Town, or	Location of Death			unty of Death	
			Mercy Med	ical Conter		Balti	more		13	altic	nore
	Funeral		Social Security Number 6. S	7. Age (In yrs. Ia	st birthday)	If Under 1 Year	if Under 24 Hrs.	8. Date of Birth	1	9. Birth	place (State or Foreign intry)
1	Director		NIA 1	X M 2□ F	Yrs.	Months Days	Hours Min.	(Month, Day	5/2001		aryland
	pu ,		Usual Residence of Decedent	140 63							/
	arylar phoy	_	10a. State 10b. County		Town or Lo	cation					10d. Inside City Limits
	Ba-f	cto	MD Baltin	nore City 1	Salt	imore					1 SaYes 2 No
	iff if	Dire	10e. Street and Number			10f. Zip Code		1	10g. Citizen	of What Cou	intry?
	ath w	rai	1605 Sprai	Court		2121	ר ל ו		<u></u>	LSA	
	e de me	Funeral Director	11. Marital Status	12. Was Decedent Ever in U.S Armed Forces?		Was Decedent of Hi f Yes, specify Cuba	spanic Origin? (Spe n, Mexican, Puerto I	cify Yes or No- Rican, etc.)		Race - Ameri Black, White	
36	s afte	by F	1 Never Married 2 Married	1 ☐ Yes 2 ∰ No If Yes, Give		1 ☐ Yes 2 🛣 No	Specify:		Spe	ecify: 10 1	
21215-0036	72 hours after death with the Maryland Inatural, or Items 23a or 28a-f ehow Alcel Evand or Ither Levillied at	d b	3 Widowed 4 Divorced	Year or Dates:	10- 0						lack
75	n 72	Completed	15. Decedent's Ed (Specify only highest gra		(Give	dent's Usual Occupa kind of work done d DO NOT use retired,	luring most of worki	ng	166. Kind o	of Business/Ir	ndustry
7	withi ene. then	E G	Elementary/Secondary (0-12)	College (1-4or 5+)	,,,o	NIA	,		NI	A	
2	filed Hygi ther	ŭ	17. Father's Name (First, Middle, Last)			10 (11	18. Mother's Name	(First, Middle,			
an	d be antat	o Be	Vista Ha	201						~	
2	thoul mark mati	은	19a. Informant's Name/Relationship (7	vpe. Printl	19b Mailin		Alccia				o Codel
Maryland	d2 stith ar		~ ~ .	1							
á	1 an Heal tem 2		alicia Shartell 20a. Method of Disposition	20b. Pla	ce of Dispo	sition (Name of	'D	ate	20c. Locati	on - City or T	2/2/7 own, State
Baltimore,	ages int of t: If li		1 🖫 Burial 2 🗆 Cremation 3 🗆	Removal from State	netery, cren	natory or other place	' I .	_	-		
=======================================	artme ortan injury		* 4 □ Donation 5 □ Other (Specify 21. Signature of Funeral Service Licenter)		10 0	Medral Name and Addres		07	Dai	hmod	re, MID
Ba	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other then "natural", or Items 23a or 28a-f show any injury or other traumatic event, it a Medical Exactions must be radiified at once.	1 1/2	Detalk	-	7	PA, 2134		Spring		, 212	weral Home, 22
*			23a. Part1. Enter the disease, or comp shock, or heart failure. List only	lications that caused the death. one cause on each line.	Do not ente	er the mode of dying	g, such as cardiac o	r respiratory arr	est,		Approximate Interval Between
ğ -	Physician		Immediate Cause (Final disease or condition	. Extre	me	Prem	+440.+				Onset and Death
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	Examiner		Sequentially list conditions,	b							
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	and trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c						_	
8760,	cate be executed physician and the burial-transit	E		Due to (or as a conseque	ince or).					1	
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9 ×		/Me	IF FEMALE:	23c. If yes, outcome of pregnance	201						
Вох	death certific e at ending p id for use as	ian	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2 ☐ Fetal d	léath 3	Ectopic pregnancy			23d.	Date of deliv Month	ery Day Year
o.	0 0 2	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at time of dea 9□ Unknown	un 5∟	Other (specify)					
<u>α</u>	that t	by Physician/Me	Part II. Other significant conditions co	ntributing to death but not result	ing in the ur	nderlying cause give	in in Part I	23e. Did to	bacco use o	contribute to I	the cause of death?
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Record	has has	Completed						24a. Was a autops perform	sv	prior to co death?	opsy findings available ompletion of cause of
<u>=</u>	iician: The certificate ha								2 2 No	1 ☐ Yes	2□ No
Vital	Physician: this certific ral director,	Be	25. Was case referred to medical examiner?	Hospital:		Othe	26. Place of Death				
ō	Phys this ral di	7	1 ☐ Yes 2 ♠No 27. Manner of Death	1754npatient 2 LEI	R/Outpatien 8b. Time of	t 3 DOA 28c. Injury	4 Nursing Hon	ne 5 Reside			fy)
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S	or Attending after death. Director: After in by the fune	ical	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury - At hom	e farm str			98f Location (S)	treet and Ni	imber or Pur	al Route Number,
Division	after Dire	Certification:	4 Homicide determined	building, etc. (Specify)	ie, iaiii, siit	ser, ractory, office	· ·	City or Town		mber or nor	ar noute warrber,
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	To the Hospital or Atten within 24 hours after deat To the Funeral Director: completely filled in by the	edicai	(Check only 2 Medical Exam	iner: On the basis of examination and manner stated.	n and/or inv	restigation, in my op	inion, death occurre	ed at the time, d	ate and pla	ce, and due t	to the cause(s)
	To the within 2 To the complet	Σ	29b. Signature and little of certifier	Carl	-	29c. License	number	2	· ·	ned (Month,	
,			Kenler	W Veen	()	71) D2	4742		09-	26-	2007
×			30. Name and address of person who o	ompleted cause of death (Item 2	(Type, I	Print)		0.	~		2007
0		Ų.	Steven W	,	m.0.	301 S	+ Pau	1 Plac	e, 13	alter	nore mo
	Sta		31. Date filed (Month, Day, Year)	32 Registrar's Signatu	ге	. 12 1					21207
	Registr	ar,	OCT 1 8 20	1/ 1862	1.00	13.52					

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Nathanieł Benjamin	1- For State Registrar	•	nt of Health and Mental F te of Death	lygiene Reg. No.	2007 331.5
Physician/ Medical Examiner	1. Decedent's Name (First, Middle,La	Benjamin	4b. City, Town, or Location of Deal	2. Date of Death Month Day October 12, 200	3. Time of Death 1130 hrs County of Death
	In front of 11422 Reisters	town Road	Owings Mills		Baltimore County
Funeral Director	5. Social Security Number 6. s 220 · 02 · 44 (6 3 1)	F 7. Age (In yrs. last birth	day) If Under 1 Year If Under 24Hi Months Days Hours Mi Yrs.		DD/YYYY) 9. Birthplace (State or Foreign Country) N
and I show any unce.	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town o	r Location Utimore		10d. Inside City Limits 1 Yes 2 No
Baltimore, MD 21215-0036 Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Montal Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatite event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	10e. Street and Number 1124 Coh5 L 11. Marital Status	Q n e	10f. Zip Code 21229	u.s	zen of What Country?
s after death with uiner", or items 23 uiner must be no by Funeral	1 Never Married 2 Marrie 3 Widowed 4 Divorce	Armed Forces? 1 Yes 2 No	 Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert Yes 2 No specify: 	o Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: Dlack
5-0036 ed within 72 hours afte ed within 72 hours afte other than "matural", the Medical Examiner Completed by	15. Decedent's Education (Specify of Elementary/Secondary (0-12)	College (1-4 or 5+)	ecedent's Usual Occupation (Give kind of uring most of working life. DO NOT use re	tired)	Kind of Business/Industry
21215-0036 Ild be filed within 72 Vental Hygiene marked other than 'event, the Medical o Be Complet	17. Father's Name (First, Middle, Las Simon T. Ben	iamin, Sr.	Angelin	e (First, Middle, Maiden	am
MD 21 rd 2 should lith and Me n 27 is man aumatic ev	19a. Informant's Name/Relationship	ype, Print), 19b.	Mailing Address (Street an Fumber or 24 COOKS Lane B		· '
Baltimore, MD 2 securit. Pages 1 and 2 shou Department of Health and Mimportant: If item 27 is nigury or other traumarite	20a. Method of Disposition 1 Disposition 2 Cremation 3 4 Donation 5 Other Specification	Removal from State cremator	Disposition (Name of cemetery, y or other place)	Date 20c. L	ocation - City or Town, State
Baltimo permit. Page Department of Important: injury or oth		lene	22. Name and Address of Facility \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	rae Pike Balti	more, mo 21229 ck, or heart Approximate Interval
/Medical xaminer	failure. List only one cause on e	ach line. Multiple Injuries			Between Onset and Death
<u> </u>	Sequentially list conditions,				
d d sit sxaminer	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): Due to (or as a consequence of):			
execute an and all - trans	UNPENDED	AMENDED			
ivision of Vital Records, P.O. Box 68760, or Attending Physician: The law requires that the death cer iffcate be executive that the death. Director: After this certificate has been signed by the attending physician and in by the funeral director, page 2 should be detached for use as the burial - ratification: To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknow	23c. If yes, outcome of pregnancy 1 Live birth 2 Pregnant at time of death 5 Unknown	Fetal death 3 Ectopic pregn Other (Specify)		d. Date of delivery Month Day Year
P.O. B es that the digned by the detached	Part II. Other significant conditions		n the underlying cause given in Part I.		use contribute to the cause of death? No 3 Probably 4 Unknown
Division of Vital Records, P.O. Box 6 total or Attending Physician: The law requires that the death cer ris after death. "In Director: After this certificate has been signed by the attendited in by the funeral director, page 2 should be detached for use ertification: To Be Completed by Physicia				24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death? 1 V Yes 2 No
ician: 1 ician: 1 s certific rector, p	25. Was case referred to medical examiner?	Hospital: 1 Innation: 2 EP/Out	26.Place of Death (Check		
Sion of Vi ttending Physi death ctor: After this y the funeral dir	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury FOUND: 28b. Tir FOUND:	me of Injury 28c. Injury at Work?	ng Home 5 Resider 28d. Describe how inju Pedestrian struck	
Division of ital or Attending us after dearth The Injection of the Injection of the Injection of the Injection:	2 Accident Investigat 3 Suicide 6 Could not determine	be 28e. Place of Injury - At home, farm	n, street, factory, office building, etc.	or Town, State)	nd Number or Rural Route Number, City sterstown Road, Owings Mills, MD

10

DHMH 17 Rev 1/2001 OCME 2006

Medical (

State Registrar

29b₄ Signature and title of certifier

Margarita Korell MD.

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner

3. Registrar's Signature

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

29d. Date signed (Month, Day, Year)

October 13, 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** ctober 7:05 AM Dwer 200 /Medical or Logation of Death 4c. County of Death 4a, Facility Name (If not institution, give street and number) Examiner N/A mar 0201ta TUL If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. ast birthday) Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** Days Min. 1 X M 2 □ F Director 218-03-3571 86 1/4/1921 MARYLAND Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits show 10a. State r 28a-f show notified at 1 ☐ Yes 2 No Director MD BALTIMORE PARKVILLE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code an "natural", or items 23a or Medical Examiner must be 21234 USA 8126 CONDUIT ROAD death Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 Mary Procest No 1 Mary Procest No 1 Mary Procest No 1 Mary Procest No. 1 Mary Procest No. 2 1 Mary Procest No. 1 ☐ Never Married 2X Married altimore, Maryland 21215-0036 1 ☐ Yes 2 📆 📆 o Specify: Specify: 3 Widowed 4 Divorced WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) the MACHINIST PAPER PRODUCTS **10TH GRADE** traumatic event. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be ALFRED H. BOWEN ANNA CECILE OTTERBEIN 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health item 27 i ALMA BOWEN/WIFE 8126 CONDUIT ROAD BALTIMORE. MD 21234 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of H Important: If ite any Injury or ot once, 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) MORELAND MEM. PARK 10/20/2007 | HILLENDALE, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, P.A. TOWSON, MD 8521 LOCH RAVEN BLVD. 23a/Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Day in the past 12 months? Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9□Unknown 9 Unknown ignificant conditions contributing to death but pot resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autonsv perform 2 No 1∐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Impatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After Division or Attending 1 Natural 5 Pending investigation hours after death. Ineral Director: Aft y filled in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a To the Funeral L Hospital 1) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical

54

Registrar

29b. Signature an

29c. License number

D 63382

Baltimore, MD &

October, 16, 2007

and manner stated.

egistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

07-079	95
Carter	Harding

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

3		1. For State Certificate of Death Reg. No. Reg. No.	3342
Physicia	an/	1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of	
Medical Exami	ner	4a. Facility Name (if not institution, give street and number) AFTER October 13, 2007 4b. City, Town, or Location of Death 4c. County of Death	nis
		St Agnes Hospital Baltimore	
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (Sta	ate or
Director		218-40-3271 1XM 2 F 64 Yrs. Nov. 7,1942 Country) 1	n.D.
any		Usual Residence of Decedent	e City Limits
*	Ļ	1 1/4	s 2 No
farylar 28a-f s aton	Director	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?	
ith the Maryland 23a or 28a-f show notified at once.			
hours after death with the Maryland 'natural'', or items 23a or 28a-f she Examiner must be notified at once	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, White, etc.	Black,
ter dez		1 3 Wildowed 4 Divorced III Yes Give Year 1 1 Ves 2 1/2 No specific 1 Specific 1	K
ours af atural camin	d by	or Dates:	<u>'</u>
21 3 -	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) College (1-4 or 5+) College (1-4 or 5+) College (1-4 or 5+)	11-1
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21215-0036 uld be filed within 72 Mental Hygiene. marked other than " c event, the Medical	BeC		
21 buld 1 Me	To	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, y or Town, State, Zip Code)	
MD and 2 sh and 2 sh and 2 sh and 27 is		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City/or Town, Stat	21218
nore ages i a nt of He nt: If it		1 X Burial 2 Cremation 3 Removal from State crematory or other place)	_
6 분 을 유 교 .		4 Donation 5 Other Specify: WES Town Com October 19.24 1 BAITO . D. 21. Signatur, of Funeral Service Licensee	1.0.
Balt permit. Depart Impor injury		22. Name and Address of Facility Betts funeral service Licensee 22. Name and Address of Facility Betts funeral to me Betts funeral	21215
Physician			nate Interv
/Medical xaminer		Immediate Cause (Final disease a, Trypertensive Cardiovascolar Disease	Death
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760, icate be exphysician the burial.	Medical	UNPENDED AMENDED IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery	
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Box 68 e death certif the attending ed for use as	Physician	1 Yes 2 No 9 Unknown 4 Pregnant at time of death 5 Other (Specify)	
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Division of Vital Records, tal or Attending Physician: The law require rs after death. al Director: After this certificate has been sited in by the funeral director, page 2 should be	mo	performed? death? 1 ✓ Yes 2 No 1 ✓ Yes 2	No No
tal f	Be	25. Was case referred to medical examiner?	
1 of Vital I	P	27 Manner of Death 28a Date of Injury 28h Time of Injury 28c Injury at Work? 128d Describe how injury occurred	
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Di spital hours a	팅	4 Homicide determined (Specify) or Town, State)	
Division of Vital Records, P.O. Box 68' To the Hospital or Attending Physician: The law requires that the death certificate burs after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Medical	Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. One Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)	
To with Com	Med	and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Ye	
		Case Hallar O.C.M.E. October 14, 2007	
	ŀ	30. Name and address of person who completed cause of death (Item 23a)	
		Carol Allan, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year) 32. Registrar's Signature	
St: Regist		10 Maria 10	

			1 - For State Registrar	State of M	laryland / Depa <i>Cel</i>	artment of F rtificate of a			giene Reg. No.O. O. O.			
b	1000		Decedent's Name (First, Middle, L.)	ast)				2. Date of Dea	ath ZUU	3 Time of boom 5		
F	Physici /Medi		Eleanor C	ameron				Month 10	11 200	07 12:00 A ^M		
	Examir		4a. Facility Name (If not institution, g.)	4b. City, Town, o	r Location of Death		4c. County of I	Death		
		N.	7728 Twin Oaks			Severn If Under 1 Year	Liki lador 04 Hro			Arundel		
	Funeral Director		220-03-8024	Sex 7. A 1 M 2 √ F	ge (In yrs. last birthday) 89 Yrs.	Months Days	Hours Min.	8. Date of Birtl (Month, Day 5/13/19	9. 918	Birthplace (State or Foreign Country) MD		
	and w]	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	cation				10d. Inside City Limits		
	with the Maryland a or 28a-f show t be notified at	Ď	MD Anne A	runde1	Severn					1 □ Yes 2 XX No		
	r 28a	irec	10e. Street and Number			10f. Zip Code			10g. Citizen of Wha	it Country?		
	th with	a D	7728 Twin Oaks 1	Road		21144	' +		USA	A		
36	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f show he Medical Examiner must be notified at	by Funeral Director	11, Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced	12. Was Decedent Armed Forces 1 ☐ Yes 2 1 If Yes, Give Year or Dates:	No	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 No	lispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	Black, \	American Indian, White, etc. white		
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21215-0036	within 7 iene. than "n he Medi	Completed by	(Specify only highest g	College (1-4or	5+) (Give	DO NOT use retired	during most of work d)	ang	Own Hor	ne.		
21	be filed within 72 ho stal Hygiene. id other than "natus event, the Medical	S	12		Hom	emaker						
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re,	Pages 1 and 2 ment of Health ant: If item 27 I lury or other tra	- 10	20a. Method of Disposition		20b. Place of Dispo		na)	Date	20c. Location - Cit	y or Town, State		
E	Page nent o		XXBurial 2 □Cremation 3 4 □Donation 5 □ Other (Spec		Holy Rede		· i 107	15/2007	Baltimore	e MD		
Baltimore,	permit. Pages Department of Important: If it any injury or once.		21. Si mulare 11 socral Scrab. His		M01364 1	2. Name and Addre	ss of Facility Sin			Cremation Srvc		
	*		23a. Part1. Enter the disease, or co shock, or heart failure. List on	mplications that cause y one cause on each	d the death. Do not ent	er the mode of dyir	ng, such as cardiac	or respiratory ar	rest,	Approximate Interval Between Onset and Death		
ā	Physician	Immediate Cause (Final disease or condition a Cardiovascular Disease										
7	/Medical Examiner		resulting in death)	Due to (or as	Due to (or as a consequence of):							
B	LAGIIIIICI	<u></u>	Sequentially list conditions, if any, leading to immediate cause. Extre Underlying	b. Due to (or as	s a consequence of):							
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.O. Box	at the death certifi by the attending tached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown		2 Fetal death 3	⊒Ectopic pregnancy ∃ Other <i>(specify)</i> _	у		23d. Date o Month	f delivery Day Year		
Δ.	\$ 6 €		Part II. Other significant conditions	contributing to death	but not resulting in the u	nderlying cause giv	en in Part I.	23e. Did to	bacco use contribu	ite to the cause of death?		
Records,	quires n sign ald be	d by						1 🗆 Y	res 2 □ No 3 [☐ Probably 4▼Unknown		
000	law require as been sig 2 should b	Completed						24a. Was a		re autopsy findings available		
Ä	The la	E O							rmed? dea	r to completion of cause of th? Yes 2X No		
Vital	sician: The certificate rector, pag	Be C	25. Was case referred to medical examiner?				26. Place of Deat					
or V	G ≅. 3	70 E	1 ☐ Yes 2XXNo	Hospital: 1 ☐ Inpat	ient 2 ☐ ER/Outpatier		4 Li Nursing He	ome 5 Resid	dence 6 □Other ((Specify)		
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Division	l or Attend after death Director:	Certification;	4 ☐ Homicide determine	d building, e	etc. (Specify)	eet, factory, office		City or Tow	vn, State)	or Rural Route Number,		
	Hospita 4 hours Funeral tely filled	Medical C	29a. Certifier 1 Certifying F (Check only one) 2 Medical Ex	Physician: To the bes aminer: On the basis and manner s	t of my knowledge, deat of examination and/or in	h occurred at the tile vestigation, in my o	me, date and place opinion, death occu	and due to the orred at the time,	cause(s) and manne date and place, and	er as stated. I due to the cause(s)		
	To the within 2 To the complet	Me	29b. Signature and title of certifier	and married o		29c. Licens	e number		29d. Date signed (A	Month, Day, Year)		
	->-0		> 5, C	D.L.	~	D006	3270		10/12/2	2007		
)		30. Name and address of person wh	completed cause of	death (Item 23a) (Type,	Print)						
_	6		Eugenia Robertson		Veterans H	wy, Suite	211, Mi	llersvil	le, MD 21	1108		
	Sta		31. Date filed (Month, Day, Year) OCT 1 8	32. Regis	trar's Signature	boute						
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DHMH 17 Rev 1/2001

			For State	State	of Marylar		artment of H		and M	ental Hy	giene	200	7	33421	5
			Registrar 1. Decedent's Name (First, Middle.	Last)		001	imodio or i	Doutin		2. Date of De		,,		3. Time of Death	_
₹.	Physici		0 1	_	00K					Month	Da		ear 0 7	5:00 PM	1
	/Medic		4a. Facility Name (If not institution,				4b. City, Town, or	r Location of	of Death	10	40	. County of I		0.1	
	LXCIIII		421 Pine Terra	ce			G1en	Burni	le			Ar	ne	Arunde1	
6	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs.		If Under 1 Year Months Days	If Under Hours	24 Hrs. Min.	8. Date of Bi (Month, D	rth	9		ace (State or Foreign	n
	Director		236-32-0610	1 □ M 2 🛣 F	88	Yrs.	Wolling Days	Tiours		Aug. 1			Oodin	ŴV	
	pu.		Usual Residence of Decedent 10a. State 10b. County		10c Cir	ty, Town or Lo	cation						10	Od. Inside City Limits	
	short short	ō	MD Anne At	runde1		Glen B								1 □Yes 2X□No	
	the N 28a-f notifie	Director	10e. Street and Number				10f. Zip Code				10a Ci	tizen of Wha	t Count	rv?	
	with a or		421 Pine Terrac	20			21061					USA	· Oouiii	,.	
	ns 23 musi	era	11. Marital Status		edent Ever in U	I.S. 13. V	Was Decedent of H		gin? (Spe	cify Yes or N		14. Race - /	America	an Indian,	_
· _	r iten riner	Funeral	1 ☐ Never Married 2 ☐ Marrie	Armed F ed 1 ☐ Yes	orces? 2.☑ No				ĭ, Puèrto F	Rićan, etc.)		Black, \			
9	urs a al",o Exan	by	3 ₩idowed 4 Divorced	If Yes, G Year or I			1□Yes 2XNo	Specify:				Specify:	whi	te	
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2	ithin ne.	ם	Elementary/Secondary (0-12)	<u> </u>	(1-4or 5+)		kind of work done DO NOT use retired			9	0	wn Hon	ne.		
2	be filed within 72 hours after death with the Maryland Ital Hygiene. d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at		12]	Homemaker			(First, Middle					_
and		Be	17. Father's Name (First, Middle, L	•						,	•	n Surname)			
Maryland 21215-0036	s 1 and 2 should be filed within 72 hours after death with the Marylan f Health and Mental Hygiene. If Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	ပ္	Emery Pierce Ro			10h Mailir	ng Address (Street		rlie			or Town Sta	ta Zin	Cade)	
<u>⊠</u>	4734						Plowmill		Seve			144	10, ZIP	oode,	
	1 and 2 Health tem 27 other tra		Mr Douglas Cook, 20a. Method of Disposition	son	20b. I	Place of Dispo	sition (Name of			ate FID		ocation - City	y or To	wn, State	
ē	Pages nent of I int: If its iry or o		1 X Burial 2 □ Cremation _4 □ Donation 5 □ Other (St		i State		natory or other place n Cemeter	1	10/	20/200	7 G	len Bu	ırni	e. MD	
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ñ	permit. Departr Importa any inju				MOR	641	2nd Ave	SW G1	en B	greton urnie	run MD 2	erai o 1061	cr	Srvc	
4	7		23a. Part1. Enter the disease, or shock, or heart failure. List	complications that	caused the deal	th. Do not ent							lï	Approximate Interval Between	
	Physician		Immediate Cause (Final disease or condition	only one cause on	Maria Na P	imer	rle	Diro	000				10	Onset and Death	
2	/Medical		resulting in death)	Due to	(or as a consec		us unet	V112	1				+	JUSEUR 13	
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×	death certific attending p	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, or	utcome pf pregn	ancy						23d. Date o	f delive	rv	
Box	death atter	ciar	in the past 12 months?		birth 2 ☐ Feta nant at time of t]Ectopic pregnancy]Other <i>(specify)</i>	У				Month		Day Year	
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ري ص	w requires that the d been signed by the should be detached	by P	Part II. Other significant condition	ns contributing to	death but not res	sulting in the u	nderlying cause giv	en in Part I		23e. Did	tobacco	use contribu	te to th	e cause of death?	
ğ	equire en sig	ed	- Kypar Here	im						1 🗆	Yes 2	No 3[] Prob	ably 4 □Unknow	n
ပ္ပ	ne law re has be ye 2 sho	Completed								24a. Was		24b. Wei	e autor	osy findings available npletion of cause of	е
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	Physion this or this or the direction of	၉	1 ☐ Yes 2 No			ER/Outpatier		4 🗆 N		ne 5 Res			Specify)	
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Division or	I or Attending P after death. I Director: After t I in by the funera	Certification:	4 ☐ Homicide determi	ned 200. Flac	ding, etc. (Speci	fy)	eet, factory, office		4	City or To	own, Sta	ria Namber ('e)	н пига	l Route Number,	
	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending p completely filled in by the funeral director, page 2 should be detached for use as		29a. Certifier .1 Certifyin	g Physician: To th	e best of my kn	owledge, deat	h occurred at the ti	me, date a	nd place, a	and due to the	e cause(s) and mann	er as st	ated.	
	To the Hospita within 24 hours To the Funeral completely filled	edical	(Check only 2 Medical I one)	Examiner: On the	basis of examin nner stated.	ation and/or in	vestigation, in my o	opinion, dea	ath occurr	ed at the time	e, date ai	nd place, and	due to	the cause(s)	
	To the within 2 To the comple	Me	29b. Signature and title of certifier	7)			29c. Licens	se number			29d. D	ate signed (A	Month, i	Day, Year)	
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	٦		30. Name and address of person	who completed cau	ise of death (Iter	m 23a) (Type,	Print) 1845	- Oak	Werz	Rind	1 5	nite.	307)	
	7		SALVACION	D. RAM	1142	M.D.	, bile	Bu	nie	u	1) 0	2106			
	Sta Registr		31. Date filed (Month, Day, Year)		egistrar's Sign	J. A	parti								
	- regioti	*	UUILO	2001	-	7.0	*								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** 2007 Hilda Dobson 10 13 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Sinai Hospital Baltimore N/A If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 □ M 2 🗙 F Yrs. 215-16-9996 Director MD 87 Usual Residence of Decedent 10c. City, Town or Location r 28a-f show notified at 10a. State 10d. Inside City Limits 10b. County 1 ▼Yes 2 No Director MD N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ral", or items 23a or Examiner must be r 3835 Greenspring Avenue Apt. 103 21215 USA death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. within 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 'natural', or 1 ☐ Yes 2 █**X**No þ Specify 3 Widowed 4 □ Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) the Medical 16b. Kind of Business/Industry is 1 and 2 should be filed within the Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Factory 12th N/A Factory Worker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William Diggs Evangeline traumatic 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Evangeline Burrell-godsister 1123 Darley Avenue Baltimore, MD 21218 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Department of H Important: If ite any injury or ot ₩₩Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Arbutus Memorial Pk. 10/20/07 Baltimore Co. MD 22. Name and Address of Facility 21. Signature of Funeral Service Licensee MARCH FUNERAL HOME-EAST Warra ladie 1101 E. North Avenue Baltimore, MD 21202 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory are shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death PNEUMONIA Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter or de type Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physician and for use as the burial-transit certificate be executed Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) the 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed þ DEMENTIA A12heimer's 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed 1□ Yes 2 1 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 | Yes 2 | No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 28b. Time of in by the funeral 27. Manner of Death 28a. Date of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

P.O. I Division or Vital Records, To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica

completely filled

State Registrar

Medical

29a. Certifier

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

UMA

BUSINESS CENTER DRIVE 210 2. Registrar's Signature

mD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

D5059107

REINERSTOWN

29d. Date signed (Month, Day, Year)

10-17-2007

MO

21136

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** MER October 200 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BALTIMEN MONTHWES

5. Social Security Number HOSPITAL CENTER 15town If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Davs | Hours | Min. | (Month, Day, Year) 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Funeral Months 1 MM 2 F 89 217-05-8601 October 7, 1918 Ohio Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a State 10d Inside City Limits 10h. County 28a-f show Examiner must be notified at MD Baltimore Woodlawn 1 ☐ Yes 2X No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with ö 2642 West Park Dr. items 23a 21207 United States of America Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 M Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 2 should be filed within 72 hours after on and Mental Hygiene. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify. þ Specify: 3 Widowed 4 Divorced White Completed other traumatic event, the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 0 Machinist Manufacturing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Carl Ditman Ethel Marie Hazlett ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important; If item 27 is in any injury or other traum once. 2642 West Park Dr., Woodlawn, MD 21207 Rita C. Ditman (wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Woodlawn Cemetery October 19,2007 Woodlawn, MD 21207 22. Name and Address of Facility Loring Byers Funeral Directors, In 8728 Liberty Rd, Randallstown, MD 21133 nv0891 Part1. Enter the diseas shock, or hear failure. ase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, e. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician NEUMONIA /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner and use as the burial-tran Due to (or as a consequence of): attending physician pe Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Year Day 4□Pregnant at time of death 5 ☐ Other (specify) 1 Tyes 2 No. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? CHARNIC FIREILLATION 1 ☐ Yes 2 ☐ No 3 Probably 4 □Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy performe CELEBROVASCU BHAGIA 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Impatient 2 ER/Outpatient 3 DOA ဥ funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 1 Natural 5 Pendina death. investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

ivision or Vital Records, P.O. Box 68760

within 24 hours a To the Funeral (

State Registrar

29a. Certifier

(Check only

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Medical

29c. License number 019502

1 w certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) URLANDO

CONANAN

32. Registrar's Signature

DHMH 17 Rev 1/2001

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7-07749 obert Lee Davis	;	State of Maryland / Department of Health and Mental			7 2212
	1	1- For State Certificate of Death		. No.	7 3342
Physicia		Registrar 1. Decedent's Name (First, Middle,Last)	Date of Death Month	Day Year	3. Time of Death
ledical Examir			October 4, 2	2007	1340 hrs
		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of De 4209 Frederick Avenue Baltimore	eath	4c. County of Death N A	
) 1 · · · · · · · · · · · · · · · · ·		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24	4Hrs. 8. Date of Birth	(MM/DD/YYYY) 9. Birth	place (State or
Funeral Director		5. Social Scentify Northber 5. 55%	Min	Foreign 1945 Voi	myginia
	-	Usual Residence of Decedent	1151.		
day		10a. State 10b. County 10c. City, Town or Location	<u> </u>	L.	10d. Inside City Limits
daryland 28a-f show day 1 at once.	٦	I Maryrama 17/22			1 X Yes 2 No
daryla 28a-f	Director	10e. Street and Number 10f. Zip Code	100	g. Citizen of What Count USA	ry?
th the Maryland 23a or 28a-f sho notified at once.					
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er dea				Specify: B.	lack
5-0036 led within 72 hours after tygiene. other than "natural", the Medical Examiner	화	or Dates:		16b. Kind of Business/Ir	idustry
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21215-0036 uld be filed within 77 Mental Hygiene. marked other than c event, the Medical		KIRODETT Davis			Zip Code) 2 1 0 6 1
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatite event, the Medical Examiner must be notified at once	- 1	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number 805 Cedar Branc)	h Dr. G	len Burni	e, Maroor
e, N l and 2 Health item 3		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery,	Date	20c. Location - City or	Town, State
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Baltimore, permit. Pages I ar Department of Hee Important: If ite	-	21 Signature Funds Spring Lice	hatman-H	arris Fun	eral Home
M F G T I		Gray Juris 5240 Reisterst	own Rd B	altimore,	MQ ZIZIO Approximate Interval
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xaminer		Immediate Cause (Final disease or condition resulting in death) a. Congestive heart failure Due to (or as a consequence of):			Death
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certif	lä.	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic property of the pregnant at time of death 5 Other (Specify)	regnancy	Nontr	, ay
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isic Atter	igat	2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc.		Street and Number or Ru	ural Route Number, City
Division of Vital Rec pital or Attending Physician: The ours after death neral Director: After this certificate filled in by the funeral director, page	Certification:	3 Suicide 6 Could not be determined (Specify)	or Town, S	itate)	
Hos 74 h rely			e, and due to the caus	e(s) and manner as stat	red.
To the Hos within 24 h To the Fun	Medical	(check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occur and manner stated.	irred at the time, date		
	Ž	29b. Signature and title of certifier 29c. License number O.C.M.E.		29d. Date signed (Mo	
		James V 1 2		30.00E1 0, 2007	
d		30. Name and address of person who completed cause of death (Item 23a) Tasha Greenberg MD. Assistant Medical Examiner 111 Penn Street, Baltimore	e, MD 21201		
/U	tate				
Regis		OOT 1 0 2007 St. Amarical			

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Exami Funeral Director		216-28-0901 10M 20F	CATE CEN Age (In yrs. last bin	kr Ba		8. Date of Birth (Month, Day,	9 Birt	hplace (State or Foreign unity)
deeth with the Maryland me 23a or 28a-f chow	Director	Usual Residence of Decedent 10a. State 10b. County Ba/Amore	10c. City, Town	gemere				10d. Inside City Limits 1 ☐ Yes 2 PNo
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72 hours after de natural; or item dical Examinar	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decede Armed Force 1 Yes, 2 If Yes, Give Year or Date:	s?	13. Was Decedent of If Yes, specify Cu	f Hispanic Origin? (Spuban, Mexican, Puerto o Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit	
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yidilid ould be filed I Mentel Hyg wrked other	To Be C	17. Father's Name (First, Middle, Last) Paw Hice			18. Mother's Nam	e (First, Middle, M.	aiden Sumame) GINS	
Datitificity, Maryjailla ZIZIS-0050 permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylan Department of Heelth and Mentel thysiene. Important: if item 27 is marked other then "natural", or iteme 23s or 28s-f ehow with jujury or other traumatic event, the Medical Examiner must be notified at 2008.		19a. Informant's Name/Relationship (Type, Print) 20a. Method of Disposition 1 Burial 2 Ocremation 3 Removal from Sta 4 Donation 5 Other (Specify)	Ave 200. Place of cemeter	Mailing Address (Street B 25 Lods) Disposition (Name of y, crematory or other p.	c Farm R	d, Apr. 118	Ediner Oc. Los Hon - City or	70 2/2/9 Town, State
permit. Departmit importa eny injure.		21. Signatur — Funeral Service Lic Insee	_	PA, 2134	+ W, 110W-	DALINGK	d., 212	
Physician /Medical		23a. Part1. Enter the disease, or complications that caus shock, or heart failure. List only one cause on each Immediate Cause (final disease or condition resulting in death)	line. Ime	atra				Approximate Interval Between Onset and Death
cate be executed by spicien and the burial-transit to	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	as a consequence of	of):	tinepu	I m They	Orsease	2
To the Hospital or Attanding Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending p completely filled in by the funeral director, page 2 should be detached for use as:	Physician/Med		2 Fetal death at time of death	3 ☐ Ectopic pregnan 5 ☐ Other (specify)	ісу	photos and	23d. Date of del Month	ivery Day Year
equires that an signed by and be detailed	þ	Part II. Other significant conditions contributing to death	but not resulting in	the underlying cause g	given in Part I.		acco use contribute to	1
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ath. r: After the		27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	jury 28b. T Day Year) Ir		ury at ork? ☐ Yes 2 ☐ No	28d. Describe how	v injury occurred	
To the Hospital or Attending Physician: The Within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Certification:	4 Homicide building,	etc. (Specify)	rm, street, factory, office		City or Town,		
he Hoss in 24 ho he Fune pletely fi	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best 2 Medical Examiner: On the basis and manner	of examination and	, death occurred at the d/or investigation, in my	time, date and place, ropinion, death occur	and due to the cau red at the time, dat	use(s) and manner as te and place, and due	stated. to the cause(s)
with To t	M	29b. Signature And title of certifier ALC ALC ALC ALC ALC ALC ALC ALC ALC ALC	ling ph	YSTER L	S S 6	+2 0	d. Date signed (Monti	-2007
1		30. Name and address of person who completed cause o	death (tem 23a) (Type, Print) hay	les st	4202	Baltin	ne 2/204
Sta Registi		31. Date filed (MOC Tay Year) 2007	strar's Signature	barle				

DHMH 17 Rev 1/2001

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death Year Physician 16:02 M Russie Fay Evans October 15 2007 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Union Memorial Hospital Baltimore N/A 5. Social Security Number 7, Age (In yrs. last birthday If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 🛠 🛱 F 215-22-6203 92 Director 9-25-1915 West Virginia Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at XXYes 2 ☐ No Director N/A Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or than "natural", or items 23a or the Medical Examiner must be re 1445 Roland Heights Avenue 21211 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after inent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or itea ury or other traumatic event, the Medical Examines 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐XNo Completed by white 3 Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker In own Home unknown

Baltimore, Maryland 21215-0036 Physician

death with the Maryland

/Medical Examiner

> attending physician for use as the burial ours after death.
>
> neral Director: After this certific filled in by the funeral director,

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician:

Be Completed by Physician/Medical Examiner

Certification: To

State Registrar 31. Date filed (Month, Day, Year)

OCT 1 8 2007

Be	17. Father's Name (First, Middle, Last)			18. Mot	ther's Name (F	irst, Middle, Maide	en Surname)		
2	George W. Preslo	ey			Ella E	dwards			
	19a. Informant's Name/Relationship (Ty	pe. Print)	19b. Mailing Address (Street and Num	nber or Rural F	Route Number, City	or Town, State,	Zip Code)	
	Ashley Nichole Hea	vel	4406 Fallsb	ridge D	Dr. Uni	t C Bali	timore,	MD 21211	
	20a. Method of Disposition	00	ace of Disposition (Name emetery, crematory or oth	of	Date		Location - City or		
	1 ☐ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	Met	ro Cremator	У		/2007 Cat	tonsvill	e, Maryland	
	21. Signature of Funeral Serfice License	apula	3631 F	-Henss- alls Ro	Seitz ad_Ba	Funeral H ltimore,	Home, In Marylan	c. d 21211	
	2 Part1. Enter the vis. ase, or compli shock, or heart foure. List only or	cation that caused the death.	. Do not enter the mode	of dying, such	as cardiac or r	espiratory arrest,		Approximate Interval Between	
0	Immediate Cause (Final disease or condition resulting in death)	Sepsis					~	Onset and Death	
ıminer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consequence). Due to (or as a consequence)	icile col	itis				12 days	
dical Exa	resulting in death) Last	Due to (or as a consequent	ence of):						
Be Completed by Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ■ No 9 □ Unknown 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify) □ 9 □ Unknown							elivery Day Year	
ed by Ph	Part II. Other significant conditions cor	ntributing to death but not resul	lting in the underlying cau	se given in Par	t I.	23e. Did tobacco	use contribute to the cause of death? ⊇⊠No 3 ☐ Probably 4 ☐ Unknow		
Complet						24a. Was an autopsy performed? 1∐ Yes 2 ☑	prior to death?	utopsy findings available completion of cause of s 2 □ No	
Be	25. Was case referred to medical examiner?			1	ce of Death (C	Check only one)			
ပ	1 Yes 2 No		ER/Outpatient 3 DOA	Other: 4 🗆	Nursing Home	5 Residence	6 □Other (Spe	ecify)	
ation:	27. Manner of Death 1	28a. Date of Injury (Month, Day Year)	28b. Time of 28c Injury M	c. Injury at Work? 1 □ Yes 2 [I. Describe how in	jury occurred		
Medical Certification: To	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - At hor building, etc. (Specify)	me, farm, street, factory,	office	28f	Location (Street City or Town, Sta	and Number or Fi ite)	lural Route Number,	
edical (29a. Certifier (Check only one) 1 Certifying Physical Examination (Check only one)	sician: To the best of my know ner: On the basis of examinati and manner stated.	vledge, death occurred at ion and/or investigation, i	the time, date n my opinion, d	and place, and leath occurred	d due to the cause at the time, date a	(s) and manner a and place, and du	s stated. e to the cause(s)	
Σ	29b. Signature and title of certifier		29c.	icense numbe	r	29d. [Date signed (Mon	th, Day, Year)	
	> magenis	R MD		2438	3946	00	tober	15,2007	
	30. Name and address of prison who co			toleno	rial	Hospit	al 1	D	

DHMH 17 Rev 1/2001

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Month Year 3 SM PHILIP J. ENZENGA, JR. october 15 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimere washington medical Center GICA BUTAJE
If Under 1 Year If Under 24 Hrs. Anne Arundes 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Security Number **Funeral** Months 1 X M 2 □ F Days Hours Director 212-34-6684 1937 MARYLAND JAN. 16, Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County ns 23a or 28a-f show must be notified at 1 ☐Yes 27 No Director MARYLAND ANNE ARUNDEL GLEN BURNIE 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 21061 UNITED STATES 1707 MANNING RD. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status ı "natural", or item: ledical Examiner n Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates: 154-158 þ Specify: 3 ☐ Widowed 4 💆 Divorced WHITE Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry the Medical (Give kind of work done during most of working life. DO NOT use retired) Maryland 2121 Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) ELEVATORS INSTALLER 9 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be AGNES MARIE SCHEMM ဥ PHILIP ENZENGA, SR. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2: Department of Health a Important: If item 27 Is any injury or other trau 233 WILLIAMS RD. GLEN BURNIE, MD21061 PHYLLIS ENZENGA / DAUGHTER Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State OCT. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) 2007 BALTIMORE CITY, MD NEW CATHEDRAL CEMETERY 21. Signature of Funeral Service Licensee 22. Name and Address of Facility KIRKLEY-RUDDICK FUNERAL HOME, P.A. 421 CRAIN HWY. SE; GLEN BURNIE, MD 21061 23a. Part1. Enter the disease, or comp or tions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any rearing to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Box 68760, IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) P.O. s been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 Probably 4 Gunknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an page 2 s autopsy performed urbh 1∐ Yes 2 No Physician; 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2/4/10 1 ☐ Yes 1 I Impatient 2 ER/Outpatient 3 DOA Medical Certification: To funeral 27. Manne of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After To the Hospital or Attending 1 Natural (Month, Day Year) 5 Pending investigation ours after death.

neral Director: A
filled in by the fu 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 28c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year, 0 30. Name and address of person who completed cause of death (Item 23a) (Type, P 0 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

12019G

Joanne Marie Fisher 07-07991 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene **UNK UNK** 2007 33434 3. Time of Death 1- For State Certificate of Death Reg. No. Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day October 13, 2007 0523 hrs **Medical Examiner** Fischer Joanne Marie 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Baltimore** University Hospital 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year If Under 24Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 6 Sex **Funeral** Foreign Months Hours Min Days Director Country) NOV 7 1961 NY 45 Yrs 047-68-8502 M 2**X** F Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County Yes 2 X No 'natural", or items 23a or 28a-f show Examiner must be notified at once. MD Brooklyn Park Anne Arundel Director death with the Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21225 UNK Plum Street Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, Funeral 12. Was Decedent Ever in U.S. 11 Marital Status Armed Forces? White, etc. 1 X Never Married 2 2 X No Yes Baltimore, MD 21215-0036
permit. Pages I and 2 should be filed within 72 hours after of
Department of Health and Mental Hyglene.
Department of Health and Mental Hyglene
injury or other transmetic event, the Medical Examiner in White If Yes, Give Yeer Yes 2 X No specify: Specify: Widowed Divorced è 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) 12 Clerk Hardware Com 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Lawrence Fischer Marie Rufer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Marie Fischer - mother 7829 Titan Court, Pasadena, MD 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 20a. Method of Disposition crematory or other place) Burial 2 🗙 Cremation 3 🗌 Removal from State Metro Crematory, Inc. 10/18/2007 Baltimore, MD Donation 5 Other Specify: 21. Signature of Funeral Service Licensee

Steven H. Williams

22. Name and Address of Facility

Cremation Society of Maryland, In 299 Frederick Road, Baltimore, MD

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician Between Onset and failure. List only one cause on each line /Medical Death a. Multiple Injuries Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and - transit The law requires that the death certificate be executed Physician/Medical AMENDED attending physician or use as the burial -UNPENDED Box 68760 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Year Live birth Fetal death Pregnant at time of death 5 Other (Specify) signed by the atte 1 Yes 2 No 9 ✓ Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, P.O. ð Yes 2 ✓ No 3 Probably 4 Completed 24b. Were autopsy findings available been 24a. Was an prior to completion of cause of autopsy certificate has b rector, page 2 sh performed? death? 1 🗸 Yes No 26.Place of Death (Check only one) 25. Was case referred to medica Be Otherexaminer? Hospital: 1 Inpatient 2 ✓ ER/Outpatient 3 Nursing Home 5 Residence 6 1 V Yes No 28a. Date of Injury (Month, Day, Year) FOUND: 28d. Describe how injury occurred 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death Certification: Passenger auto collision

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director; After this certific Division of Vital within 2 To the J

neral Director;

30. Name and address of person who completed cause of death (Item 23a) Ana Rubio MD. Assistant Medical Examiner 31. Date filed (Month, Day, Year) State

Pending

Could not be

determined

2007

Oct 13, 2007

Natural

Suicide

Homicide 29a. Certifier

29b. Signature and title of certifier

2 Accident

3

g

د Registrar's Signature ک

(Specify) Major Road / Highway

FOUND:

0012 hrs

28e. Place of Injury - At home, farm, street, factory, office building, etc

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

1 Yes 2 No

29c. License number

O.C.M.E.

28f. Location (Street and Number or Rural Route Number, City

October 14, 2007

29d. Date signed (Month, Day, Year)

or Town, State) 2401 Hawkins Point Road, Baltimore , MD

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. anend item little per fin 87/2 10-18-07 vt.
State of Maryland / Department of Health and Mental Hygiene 2007 33435 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 2007 ma Grove l0 /Medical 4c. County of Death Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Randallstown 9109 Liberty Rd Rand all stown der 1 Year | If Under 24 Hrs. timare Genesis Country 5. Social Security Number If Under 1 Year 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) April 25,1926 6. Sex Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🕅 F Days Min. Months Yrs. Director 220-18-8301 81 April Baltimore, Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County or 28a-f show 10d. Inside City Limits 1 Yes 2 No Director N/A Baltimore 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code ir then "naturel", or items 23a or USA 1908 Ramsay St. 21223 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ②No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 X No Specify: 3 ☐ Widowed 4 🖔 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) 11 State of Maryland N/A Toll Collector 7 is marked other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be and Mental Annie Dahlweiner Clarence Feuchtenberger 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 i Gilbert E. Hellman/Son 431 Heritage Dr. Gettysburg, PA 17325 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Oct. 17, 20c. Location - City or Town, State Department of Himportant: If its eny injury or of once. 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 2007 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, MD Metro Crematory 21 Signsture of Fun (a) Service Liansee 22. Name and Address of Facility Loring Byers Funeral Directors 8728 Liberty Road Randallstown, MD 21133 QQ W. Lori: 8728 Bryan Clary 23a. Part1. Finter the disease, or complications that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart ailure. List only one cause of each ine. Approximate Interval Between Onset and Death Immediate ause (Final disease or ondition resulting in de stage rena Pnysician /Medical Due to (or as a confuence of Examiner omnan Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner insequence of) The law requires that the death certificate be executed attending physicien and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months 1 Yes 2 No Month Day Year 4☐Pregnant at time of death 5 Other (specify) ned by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by should be o 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has I autopsy performed? 2 / M 1 ☐ Yes 2 ☐ No 1 ☐ Yes or Attending Physicien: director Medical Certification; To Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Cther: 4 Jurising Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this After thi 28a. Date of Injury (Month, Day Year) 27. Manner 1 ath 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Unatural 5 Pending death. illed in by the fu investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours after To the Funeral Dire To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check ont 29b. Signature and title 29c. License number 29d. Date signed (Month, Day, Year)

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

(Item 23a) (Type, Print)

ral's Signature

32. Regi

		t in Black Indelible Ink. Ensure A	
	1- For State of Ma	ryland / Department of Health and N Certificate of Death	Reg. No. 2007 331, 36
Physician /Medical	Decedent's Name (First, Middle, Last) BRADY GRAHAM JR		2. Date of Death Month Day Year OCT.16,2007 9:15P M
Examiner	4a. Facility Name (If not institution, give street and number) 809 N. Collington Ave.	4b. City, Town, or Location of Death BALTIMORE	4c. County of Death N/A
Funeral Director	216 20 3696 ¹ ⅓ ^{M 2□F}	81 Yrs. If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Year) JULY 29,1926 MARYLAND
r 28a-f show notified at	Usual Residence of Decedent 10a. State 10b. County N/A	10c. City, Town or Location BALTIMORE	10d. Inside City Limits 1√☐ Yes 2 ☐ No
with the N ta or 28a-1 t be notifi	10e. Street and Number 809 N. Collington Ave.	10f. Zip Code 21205	10g. Citizen of What Country?
filed within 72 hours after death with the Maryland Hygiene. Hygiene. what than "natural"; or items 23a or 28a-f show ant, the Medical Examiner must be notified at ECOMPLET Director	11. Marital Status 12. Was Decedent E Armed Forces? 1 \[\text{Never Married} \ 2 \[\text{Married} \] 12. Was Decedent E Armed Forces?	If Yes, specify Cuban, Mexican, Puerto	
72 hours a "natural", o dical Exan	37 Widowed 4 Divorced Year or Dates. 15. Decedent's Education (Specify only highest grade completed)	8/45 11/13/46 16a. Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired)	Specify:BLACK 16b. Kind of Business/Industry
permit. Pages 1 and 2 should be filed within 72 hou Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natura any Injury or other traumatic event, the Medical E once. To Be Completed	Elementary/Secondary (0-12) College (1-4or 5-8) 17. Father's Name (<i>First, Middle, Last</i>)	LABORER	CITY OF BALTIMORE e (First, Middle, Maiden Surname)
Mental H arked oth attic even	BDYDA CDYHYM CD	E M. MILBURN	
and 2 sho salth and P 1 27 is ma er trauma	19a. Informant's Name/Relationship (Type. Print) LYNETTE REED (daughter		ral Route Number, City or Town, State, Zip Code) BALTO, MD. 21212
Pages 1, nent of He ant: If iten ury or oth	20a. Method of Disposition 1 □ ₽urial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)	20b. Place of Disposition (Name of cemetery, crematory or other place) BALTIMORE NATIONAL CEN	Date 23,20 7 BALTIMORE, MD,
permit. Departi Importa any Inj	21 Signature of Funeral Service Licensee		GGS FUNERAL HOME N ST. BALTO,MD. 21213
Physician /Medical	23a. Part1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each lin Immediate Cause (Final disease or condition resulting in death)	the death. Do not enter the mode of dying, such as cardiac e. CAN CEL a consequence of):	or respiratory arrest, Approximate Interval Between Onset and Death 2 YEACS
executed n and ial-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a Due to (or a) Due to (or a) Due to (or as a Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due t	a consequence of):	
The law requires that the death certificate be ate has been signed by the attending physicia page 2 should be detached for use as the bur completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 1 □ Live birth 1 □ Live birth 2 □ No 9 □ Unknown	2 ☐ Fetal death 3 ☐ Ectopic pregnancy	23d. Date of delivery Month Day Year
w requires that the deben signed by the should be detached leted by Physic	Tate in Street Significant Contained and Con	it not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown
: The law requii			24a. Was an autopsy performed? performed? 1
sician: certific rector,	25. Was case referred to medical examiner?	Other	th (Check only one)
To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page Medical Certification: To Be Com	27. Manner of Death 1 PNatural 5 Pending investigation 2 Accident 28a. Date of Injur (Month, Day	y 28b. Time of 28c. Injury at	ome 5 MR Residence 6 □ Other (Specify) 28d. Describe how injury occurred
To the Hospital or Attending F within 24 hours after death. To the Funeral Director: After completely filled in by the funeral Medical Certification:			28f. Location (Street and Number or Rural Route Number, City or Town, State)
o the Hosp ithin 24 hou o the Fune ompletely fil	(Check only one) 2 Medical Examiner: On the basis of and manner sta	of my knowledge, death occurred at the time, date and place examination and/or investigation, in my opinion, death occuted. 29c, License number	
5 kit) JAR M	D005 789	October 17, 2007
) / \		eath (Item 23a) (Type, Print) Odwy Bothwore, Print) ar's Signature	IESIS di
State Registrar	OCT 1 8 2007	e & finde	

State of Maryland / Department of Health and Mental Hygiene, Reg. No. 2007 33437 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** Carolyn Hutchins 2007 9:45 a October 16 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Skyway Manor Annapolis Anne Arundel 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 8. Date of Birth (Month, Day, Year) APR 2 1919 Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 1 ☐ M 2 🗶 F 88 Ohio 263-18-4077 Director Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene.

em 27 Is marked other than "natural", or items 23a or 28a-f show ther traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10a. State 10d. Inside City Limits 10h. County "natural", or items 23a or 28a-f sh edical Examiner must be notifled Director 1 ☐ Yes 2 No MD Anne Arundel <u>Annapolis</u> 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 919 Melvin Road USA Funeral 21403 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 3 Widowed 4 ☐ Divorced 1 ☐ Yes 2X If Yes, Give Year or Dates: altimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify Completed by Specify: White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Edward Francisco Mary 2 Bernard 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Roy Hutchins - son 130 South Homeland Avenue, Annapolis, MD 21401 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Pages 1
Department of H.
Important: If Iter
any Injury or oth Date 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metro Crematory, Inc. 10/17/2007 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, MD 21. Signature of Funeral Service Licensee

Steven H. Williams Name and Address of Facility
Cremtion Society of
299 Frederick Road, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical as attending p for use as IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown s been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 📈 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform certificate 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? funeral director. SKY WAN Be 26. Place of Death (Cneck only one) Hospital: 1 ☐ Inpatient Other: 4 \sum Nursing Home 1 Tyes 2 ER/Outpatient 3□ DOA မှ 5 ☐ Residence 6 Other (Specify) this 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: (Month, Day Year) 1 Natural 2 ☐ Accident 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No hours after deat uneral Director: 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours a 1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated. within 2 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State

OCT 1 8 2007

Year

31. Date filed (Month, Day,

ngeted cause of death (Item 23a) (TyperPrint)

TOTA WO 44 DEFENSE HIGHWAY ANNAPOLISM D21401

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month Year Konald 03:41PM october 09 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner of Maryland Medical center University Ba Himore If Under 1 Year Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1⊠M 2□F 227-70-3873 56 Oct. 1950 Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a. State 10b. County show 10d. Inside City Limits 28a-f sh notified 1 ☐ Yes 2 ☑ No Directo Anne Arundel Maryland Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or 7 115 Kuethe Road 21060 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or Items 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify White Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) traumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Salesman Cars 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Hall Silvia Duff ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health a Donna M. Hall (spouse) <u>115 Kuethe Road, Glen Burnie. MD 21060</u> 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Department of H Important: If ite any Injury or ot once, 0ct 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Metro Crematory Inc. 4 ☐ Donation 5 ☐ Other (Specify) 2007 Baltimore, Maryland 21. Signature Funeral Service Licenses 2. Name and Address of Facility Stallings Funeral Home, P.A. Mountain Road, Pasadena MD 21122 23a. Part1 Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Mixocardial **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Carongry arteny Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav 5 ☐ Other (specify) P.O. this certificate has been signed by the a ral director, page 2 should be detached it 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed 2 100 or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2000 ပ္ 1 Impatient 2 ER/Outpatient 3 DOA funeral To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifie 29c. License number 17-341 WP 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore, MD 2120 GOOSH ESH 57. HOREH

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 200 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Yea **Physician** Hanna 11.45AM lierra 10 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Belaix Hospitai If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Security Number **Funeral** Months Days Min 1 ☐ M 2 MF 219-06-8301 Director Usual Residence of Decedent hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits ral", or items 23a or 28a-f show Examiner must be notified at 1 Yes 2 No berdeen Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21001 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11, Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Never Married 2☐ Married "natural", or 1 ☐ Yes 2 No Specify: Specify: 2 3 Widowed 4 Divorced Completed the Medical 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Food Service Pashier s 1 and 2 should be filed w f Health and Mental Hygier ttem 27 is marked other tt or other traumatic event, Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ Pages 1 and 2 should 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CINNAMON 11/2//33 TANNA USh ONa permit. Pages 1 an Department of Heal Important: If item 2 any injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1⊠Surial 2 □Cremation 3 □Removal from State 4 □ Donation 5 □ Other (Specify) Cernatar 22. Name and Address of Facility Charman Harris 4210 21. Signature of Funeral Service Licensee SF 1 21206 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** OLONIC. MERFORATION 27 hours /Medical Due to (or as a consequence of): Examiner COLITIS 1 Month Sequentially list conditions, if any lead in to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner SYNDROME HEGVIRED 1 MMUND DEFICHMLY Due to (or as a consequence of) Physician/Medical IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy for Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9 Linknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by pe 1 ☐ Yes 2 No 3 Probably 4 Unknown director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1□ Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes npatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after death • Funeral Director: 3 Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated. within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and 0056296 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 32 Registrar's Signature State 1 2007 8 Registrar

DHMH 17 Rev 1/2001

DHMH 17 Rev 1/2001

State Registrar

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10,

OCTOBER

EUGENE HOPKINS

TIMONIUM, MD 21093

2300 DULANEY VALLEY RD.

32 Registrar's Signature

B. State of

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR. TARIQ MAHMOOD

OCT 1 8

31. Date filed (Month, Day, Year,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2007

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			HINES				Month	Day Year 13, 2007	7:00 P
Medic kamin		4a. Facility Name (If not institution, give			4b. City, Town, o	r Location of Death	OCTODER	4c. County of Death	1 / • 00 F
		2915 Coale Lane			Church			Harford	
neral ector		5. Social Security Number 6. S 507–24–6963 Usual Residence of Decedent	9x 7. Age (In yrs. ▼ M 2 F 7.	Ven	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, You Nov. 3,		place (State or Fore ntry) Taska
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afic	2	Wallace Woodford						e Kistler	
Iraun	0.3	19a. Informant's Name/Relationship (7		19b. Mailir	ng Address (Street	and Number or Rura	il Route Number, C	ity or Town, State, Zip	Code)
ther		Sarah Emily Hines 20a. Method of Disposition	/ Wife	2915	Coale La	me, Churc	hville, 1	D 21023 c. Location - City or To	own State
0 0		1 ☐ Burial 2 ☐ €remation 3 ☐	Removal from State	cemetery, crer	natory or other plac	ce)	1	70.	
any injury or other once.		4 ☐ Donation 5 ☐ Other (Specify 21. Anature of Funeral Service Licen				orp. 10-18		owson, Mar	yLand
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phould	Certification: To Be Completed by	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigation 3 Suicide 6 Could not be determined 29a. Certifier (Check only one) 29b. Signature and title of certifier 30. Name and address of person who	9 Unknown Ontributing to death but not resemble to the properties of the properties	ER/Outpatien 28b. Time of Injury ome, farm, str owledge, death	other (specify)	en in Part I. 26. Place of Death er: 4 \(\text{Nursing Hot} \) y at k? Yes 2 \(\text{No} \) ne, date and place, pinion, death occurr e number	1 Ves 24a. Was an autopsy performe. 1 Yes 2 2 2 3 (Check only one) The state of the control of the c	Month Coo use contribute to the cool of	tated. Day, Year) Year Year A possible of death Day, Year)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Frederick Michael Hatch 10/13/2007 4:13 pM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Harbor Hospital Baltimore If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth 6 Sex 7. Age (In vrs. last birthday) **Funeral** 09/24/1953 Days Hours 54 210-36-6212 1**∑**M 2□ F PA Director Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County show r 28a-f show notified at MD Baltimore 1 X Yes 2 No Director 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? "natural", or items 23a or dical Examiner must be 21230 USA 440 East Fort Avenue Funeral death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. int: If item 27 is marked other than "natural"; or ite 1 ☐ Yes 2 📉 No If Yes, Give Year or Dates: 1 Never Married 2KM/arried White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: <u>م</u> 3 Widowed 4 Divorced Completed 7 is marked other than "natu traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Education Teacher 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Margaret Ruth Whyte Frederick Miller Hatch ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 440 East Fort Avenue, Baltimore, MD 21230 19a. Informant's Name/Relationship (Type. Print) Janice E. Hatch / Wife item 27 other to 20b. Place of Disposition (Name of cemetery, crematory or other place, Bayview Crematory Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☑ remation 3 ☐ Removal from State Department or Important: If i any injury or once. = 5 Baltimore, MD 10/18/2007 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses Wens Funeral Home Inc. Avenue, Baltimore, MD 21230 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Myocardia **Physician** Mins disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Atherosalistic Cardio vouscilor Disease ysecter an Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown 3 Ectopic pregnancy in the past 12 months? signed by the aid be detached for 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed? Yes 2 2 No 1□ Yes To the Hospital or Attending Physician; 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ☐ R/Outpatient 3 ☐ DOA 1 Inpatient Certification: To 28a. Date of Injury 28b Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day 5 Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No iours after death.

neral Director; /
filled in by the fi 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funeral C 1XI Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)
October 16, 2007 29c. License number 396660 1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) or the Bultimare, MD 212 30 Kobert 901 31. Date filed (Month, Day, Year) etrar's Signature State OCT 1 8 2007 Registrar

			1 - Fortamend PEr DVR C872	State of Mar 2 10/18/07 JH	yland / [Departm <i>Certific</i>	ent of H ate of a	lealth a Death	and Me	ntal Hy	giene Reg. No 20	07	33443
-	Physici	an	1. Decedent's Name (First, Middle, Las			<u> </u>			2	. Date of De Month	ath Day	Year	3. Time of Death
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7	Examin	er	Harbor Hospital Center Baltimore								4c. County		
	Funeral Director		245 00 0.5-	TM OFF	In yrs. last biri	Yrs. If Ur Mont	hs Days	If Under 2 Hours	Min.	Date of Bir (Month, Da	th <i>ly, Year)</i> 18 , 194	Cou	
	and w		Usual Residence of Decedent 10a. State 10b. County	10	0c. City, Towr	n or Location	·	· · · · · · · · · · · · · · · · · · ·					10d. Inside City Limits
	e Maryl a-f sho tified a	ctor	Maryland N/A		Balt	imore	<u> </u>						1★TYes 2 No
	h with the	al Directo	10e. Street and Number 2609 Spelman Ro	ad Apt. E	33	10f.	Zip Code 2122	5			10g. Citizen of USA	What Cou	ntry?
5-0036	d within 72 hours after death with the Maryland giene. rr than "natural", or items 23a or 23a-f show the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☑ Divorced	12. Was Decedent Eve Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	er in U.S.		ecedent of H specify Cuba s 2 No		gin? (Speci i, Puerto Ri	fy Yes or No can, etc.)	Bla	ce - Americ ck, White, y:Bla	
7-612	within 72 ho iene. • than "natur the Medical I	Completed	15. Decedent's Ed (Specify only highest grad	ucation de completed) College (1-4or 5+)		Decedent's U (Give kind of life. DO NO	work done Tuse retired	oation during most d)	t of working		16b. Kind of B		•
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/land	uld be filed Mental Hyg trked othe	To Be	17. Father's Name (First, Middle, Last) Ford McKensie							First, Middle, nambe:	, Maiden Surnar rs	ne)	
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D E	nit. Pages 1 and 2 sh artment of Health and ortant: If Item 27 Is m injury or other traum		1 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (<i>Specify</i>		King								Maryland
Dall	permit. Departr Importa any inju		21. Signature of Foheral Service Liver	see Anie		22. Name 5240	and Addre	ss of Facility ters	y Chat town	man- Rd B	Harris altimo	Fun re,M	eralHome d 21215
	06 00		3a. Part. Enter the Jisease, or composhock, or hear ailure. List only	elications that caused the	e death. Do r								Approximate Interval Between Onset and Death
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V	be executed ician and burial-transit	Examiner	that initiated events resulting in death) Last	cDue to (or as a c	consequence of	of):							
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O. Box 6	iaw requires that the death certific. as been signed by the attending pl 2 should be detached for use as t	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	23c. If yes, outcome pf 1 □Live birth 2 [4 □ Pregnant at tin 9 □ Unknown	Fetal death	3 ⊟Ectop 5 □ Other	ic pregnancy (specify)	у				ate of deliv	ery Day Year
Z,	s that med by e deta	by Ph	Part II. Other significant conditions of	ontributing to death but r	not resulting in	the underlying	ng cause giv	en in Part I.		23e. Did t	obacco use con	tribute to t	he cause of death?
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vital Records,	2 8 2	Completed	Morle	id of	esily					24a. Was auto perfo 1∐ Yes	psy ormed2	Were auto prior to co death? 1 \(\subseteq Yes	opsy findings available ompletion of cause of
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			1 1st	Ch			Vist	341			10-	15-	07
	3		30. Name and address of person who o	completed cause of deat	th (Item 23a) ((Type, Print) Eu 7	Aw	PC,	BAC	11040	10- AE A	192	1217
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's	67		10	1					

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Ernest Α. Johnson Sr. М 10 2007 12 /Medical 6:16p. 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Harbor Hospital Baltimore 5. Social Security Number 7. Age (In vrs. last birthday) 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours Days Min 1**№** M 2□ F 214-12-8408 Director 86 10 1921 MD Usual Residence of Decedent 10a, State 10c. City. Town or Location a or 28a-f show t be notified at 10h. County 10d. Inside City Limits MD N/A Baltimore 1 Yes 2 No Director 10e. Street and Number 10g, Citizen of What Country? items 23a must 2510 Huron Street Funeral 21230 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2**X**] No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, "natural", or items edical Examiner m Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after or Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or iten any injury or other traumatic event, the Medical Examiner 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 No þ Specify Specify. 3 ☑ Widowed 4 ☐ Divorced Black Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12th N/A John K. Ruff, Inc. Truck Driver 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Douglas ပ Monroe Mary <u>Johnson</u> 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ernestine M. Johnson-daughter 2510 Huron St. Baltimore, MD 21230 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State Mt. Zion Cemetery 10/18/2007 Baltimore MD 4 Donation 5 Dother (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee MARCH FUNERAL HOME-EAST War adug 1101 E. North Avenue Baltimore, MD 21202 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Acun MYOURADIA disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner MANOGOL からか 17185-46 F Se wentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine the death certificate be executed burial-transi 141527482 ATTHEROS CUENTANC CAPALIO VAS CUCAPE that initiated events resulting in death) Last and Due to (or as a consequence of) Box 68760 attending physician Physician/Medical I Alga MIMPRITES as the IF FEMALE: nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ō in the past 12 months? Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) P.O. I 1 ☐ Yes 2 ☐ No the detached 9 Unknown 9 Unknown þ signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, g 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has autopsy perform certificate 2 **X** No 1∐ Yes Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 \subseteq Nursing Home 5 \subseteq Residence 6 \subseteq Other (Specify) Hospital: 250No ၉ 1 ☐ Yes 1 🔲 Inpatient 2 ER/Outpatient 3□ DOA this within 24 hours after death.

To the Funeral Director: After thi
completely filled in by the funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred Certification: the Hospital or Attending (Month, Day Year) 5 Pending investigation 1 Maturai 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

10

Registrar

State 31. Date filed (Month, Day, Year)

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

OCT 1 8 2007



DHMH 17 Rev 1/2001

700 WASHINGTON BUD

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- For State Registrar Amend 20b, perFH, C874, 12/11/07 TT Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** JONES Margaret To Nes

4a. Facility Name (If not institution, give street and number) ctober 1007 /Medical 4b. City, Town, or Location of Death 4c. County of Death Examiner Randalls town Northwest Bultimore Hospital Center If Under 24 Hrs. 9. Birthplace (State or Foreign Country)
MD 5. Social Security Number **Funeral** Days 1 □ M 25 F 212-34-5123 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important; If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatte event, the Medical Examiner must be notifiled at 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐Yes 2 ▼No Director Baltimore Randallstown MD. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21133 3724 Brentford Road USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Married Spec African-American Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Completed by 3 XWidowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Baltimore City School System Cafeteria Worker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Roland Jones Alice Randall ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3724 Brentford Rd., Randallstown, MD 21133 Brigitte L. Harrington/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition XX Burial 2 □ Cremation 3 □ Removal from State King Memorial Park Woodlawn, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Wylie Funeral Home P.A. of Balto. Co. 21. Signature of Juneral Service Licenses 9200 Liberty Rd., Randallstown, MD 21133 29a. Enter the discusse, or constructions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List my one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Ruptured Thoracic Aurtic Anevrysm Due to (or as a consequence of): **Physician** /Medical Examiner Sequentially list conditions, if any, bearing to initial solutions cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last District (ur as a nonsequence of) Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 menths? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Chronic 1 Yes 2 No 3 Probably 4 Unknown Renal INSSFFICIENCY 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 | Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To After this within 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier October 16,2007 00065425 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5401 Old Cost Rd Rundallstown MD 21133 Steven A Katz und 31. Date filed (Month, Day, Year) 32 Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

OCT 1 8 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** Johnson RUTICE 2007 .35 A M October /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore HospitaL HOPKINS Johns If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 1 X M 2 ☐ F 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 213-52-4805 Director 5**-17-1**948 MD Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No MD Baltimore Gwynn Oak Completed by Funeral Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 3604 Howard Park Avenue 21207 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 □ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Specify: African-American Baltimore, Maryland 21215-0036 1 ☐ Yes 21 No 3 ☐ Widowed 4 ☒ Divorced Year or Dates: 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Entrepreneur Home Improvement 12th 17. Father's Name (First, Middle, Last) Unk 18. Mother's Name (First, Middle, Maiden Surname) Be Kathryn Johnson ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Faye M. Goodie/Daughter 562 Windsong Drive, Aberdeen, MD 21001 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐Removal from State 4 Donation 5 Dother (Specify) Garrison Forest Veterans 10-17-07 Owings Mills, MD 22. Name and Address of Facility Wylie F/ H P.A. of Baltimore County 21. Simature of Funeral Service Licer 9200 Liberty Rd., Randallstown, MD 21133 da n 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 61 DEC /Medical Du to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 5 Other (specify) signed by the ar 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 🗹 No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed? 2 No To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred il or Attending F after death. Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a To the Funeral L 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar 31. Date filed (Month, Day, Year)

OCT 1 8 2007

Ani Balmanoullian.



Balmanoulvan, Medical Doctor

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Res-000

Johns Hopkins Hospital, 600 north wolfe street, Raltimore Maryland 21287

October 11, 2007

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

OCT 1 8 2007

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Wayne 12:33 PM Lockner OCTOBER 2007 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Burnt If Under 24 Hrs. BALTIMORE Washington Medical 5. Social Security Number 6. Sex 7. Age (In yrs. ANNE ARUNde GLE Center 7. Age (In yrs. last birthday Birthplace (State or Foreign Country) Days Year) 1 ☑ M 2 ☐ F 215-52-3573 59 MD Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2√☐ No Maryland Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8009 Crainmont Drive E. 21061 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐XNo Specify: Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Maintenance Supervisor 12 Housing 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Robert Lockner Eunice Μ. Webb 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8009 Crainmont Dr. E., Glen Burnie, MD 21061

e of Disposition (Name of Date 20c. Location - City or Town, State <u>Jacqueline D. Lockner</u> (spouse) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 10/19/2007 Marriottsville, MD Crestlawn Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License Stallings Funeral Home, P.A. uschel 3111 Mountain Road, Pasadena, MD 21122 23a. Pa. 1. Enter the disease, or omplications that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each time. Immediate Cause (Final Preumonia 4 weeks disease or condition resulting in death) Due to (or as a consequence of) Non - Hodg kins Due to (or as a construence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed Yes 2 1∐ Yes 26. Place of Death (Check only one) Hospital: 1 Impatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No

Examiner nding physician and use as the burial-tran Division or Vital Records, P.O. Box 68760,3 After this I Director: A

Examiner Physician/Medical þ Completed Be Certification: To Medical

Physician

/Medical

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Funeral

Director

28a-f show must be notified at

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Important; If Item 27 is marked other than "natural", or Iten any injury or other traumatic event, the Medical Examiner

d 2 should be filed within 7 th and Mental Hygiene.
7 is marked other than "

Pages 1 and 2 s ment of Health ar Health tem 27

Physician

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Completed

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death with the Maryland

Maryland 21215-0036

Baltimore,

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 25. Was case referred to medical examiner? 1 ☐ Yes 2 No 27. Manner of Death 1 Natural 2 Accident 3 ☐ Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier

29b. Signature and title of certifier

D47575

October 15, 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated

MATTHEW PARK, M.D. 305 HOSPITAL DR. STE 305. GLEN BURNIE, MD 21061

31. Date filed (Month, Day, Year) State Registrar

Registrar's Signa

DHMH 17 Rev 1/2001

V

within 24 hours a To the Funeral C

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death OCTOBER Day Year **Physician** John Lemon 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** COPITAL OF 1 SA DUYORE D'WORF n/a If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months 1₩ M 2□F Days Hours Director 249-14-0294 08/25/1917 SC Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. int: If item 27 Is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits r 28a-f show notified at Director 1 Yes 2 No Baltimore n/a 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? a or "natural", or items 23a edical Examiner must b 3611 CALLAWAY AVENUE 21215 United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Yes 2 If Yes, Give Year or Dates: 1 Never Married 2 Married 2 **N**0 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛛 No Specify. þ Specify: Black 3 Widowed 4 ☐ Divorced Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) steelworker Bethlehem Steel 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James A. Lemon ၉ Liza 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8407 Billson Road, Randallstown, MD 21133
e of Disposition (Name of Date 20c. Location - City or Town, State Joseph A. Lemon/son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Department of Important: If it any Injury or o 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Woodlawn Cemetery | 10.19.07 | Gwynn Oak, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Chatman-Harris Funeral Home 5240 Reistertown Rd, Baltimore, MD 21215 23a. Par 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shrick, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician 30 MINU /Medical TRAVASCULAR CONTONCAPO, ZH **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examine Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9∏Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed 1 Yes 2 2 ☐ No Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the 29c. License number 29b. Signature and title of gertifier 29d. Date signed (Month, Day, Year)

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month l 3^{Day} OSEPH 200 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) NIA 10SPITAL AUTIM ORE Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Days Year! 1 XM 2□ F Yrs. VLAND Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 1 X Yes 2 No MARYLAND 10e. Street and Number 10g. Citizen of What Country 14. Race -Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🗷 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) RIVATE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) IOSEP 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SHIRLEY MILLER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location 1 Burial 2 □ Cremation 3 □ Removal from State 4 Donation 5 Dother (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one causy on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy
1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an 115 1□ Yes 25. Was ca referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 1 patient 28a. Date of Injury (Month, Day Year) 27, Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined

Physician /Medical Examiner be executed

Physician

/Medical

Examiner

Funeral

Director

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Baltimore, Maryland 21215-0036

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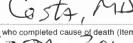
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State

completely

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier



and manner stated.

32. Registrar's Signature

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address (ferson who completed cause of death (Item 23a) (Type, Print) CO574 301 OSEPIT ST

PLACE BATI STORE, MU

3 Suicide

29a. Certifier

4 ☐ Homicide

(Check only one)

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legiple. State of Maryland Propagation 19/07 Hearth and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** James McCants 10 18 2007 8:10 Α /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore 7914 Stratman Road 6. Sex 1 M 2 ☐ F If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Month, Day, Year) Jan. 21, 1925 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days Hours Min. 579-22-9526 Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at MD Baltimore 1√T Yes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21222 7914 Stratman Road USA Funeral permit. Pages 1 and 2 should be filed within 72 hours after dean Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or income any injury or other traumatic events. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Amarried African American 1 ☐ Yes 2 ☐ No Specify: ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Methodist Minister church 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Moses McCants Millie Robinson ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bernice E. McCants / Wife 7914 Stratman Road; Baltimore, Maryland 21222 20b. Place of Disposition (Name of cemetery, crematory or other place)
Salem United Methodist
Church Cemetery 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 10/23/2007 4 ☐ Donation 5 ☐ Other (Specify) Florence, South Carolina 21. Signatule of Funeral Service Licensee 22. Name and Address of Facility Wylie Funeral Home, P.A. 638 North Gilmor Street; Baltimore, Maryland mes 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one chuse on each line. Approximate Interval Between Onset and Death with Immediate Cause (Final **Physician** opha 3 weeks disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed the bunial-tran Due to (or as a consequence of): Physician/Medical as 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 4□Pregnant at time of death 2 No 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2[] No 3 Probably 4 □Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home Hospital: 1 ☐ Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 □Other (Specify) ٩ 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation injury 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Division or Vital Records, P.O. Box 68760,

Registrar DHMH 17 Rev 1/2001

10

29a. Certifier

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

8 2007

1 🖔 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number 0 0 5 1 8 7 2

29d. Date signed (Month, Day, Year)

Crussroads #56 Catonsville un 2/228

State of Maryland / Department of Health and Mental Hygienes o o

			For State Registrar	State of Ma	aryland / D	Certific	ate of i	Death	ленан пу	Reg. No.	0 /	33452
r	Physici	an	Decedent's Name (First, Middle, La Gerald Maurice						2. Date of De	er 13, 2)) (137	3. Time of Death
	/Medic		4a. Facility Name (If not institution, gi			4b. 0	City, Town, or	Location of Death			y of Death	12:00p ^M
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8.	Funeral Director		217-22-0311	Sex 7. Age N□M 2□F	79 Y	rs. If Ur	ths Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da Jun	th 1928	9. Birth	place (State or Foreign ntry) aryland
	/land ow at		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Location			·			10d. Inside City Limits
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	h with th	al Dire	10e. Street and Number 38 Carling Circ	le		10f.	. Zip Code	21227		10g. Citizen of Unite		-
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral Director	11. Marital Status 1 □ Never Married 2 Married 3 □ Widowed 4 □ Divorced	12. Was Decedent B Armed Forces? 1 2 Yes 2 □ N If Yes, Give Year or Dates:	1000		ecedent of H specify Cuba es 2□ No	ispanic Origin? (Sp an, Mexican, Puerto Specify: Cul	ecify Yes or No Rican, etc.)	Bla	ce - Ameriack, White,	
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Baltimore, Maryland 21215-0036	und 2 shou alth and M 27 is mar	-	19a. Informant's Name/Relationship (Type. Print) Florence I. Martinez - Wife 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 38 Carling Circle, Baltimore, MD 21227									
more,	Pages 1 ar lent of Hea nt: If item 2		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ 4 □ Opnation 5 □ Other (Spec		1	, crematory	or other plac	(e)	Date 8-2007	20c. Location Brook1	1	MD
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	100		23a. Part 1. Enter the disease or cor shock, or heart failure. List only	plications that caused one cause on each lin	the death. Do no	ot enter the	mode of dyin	g, such as cardiac	or respiratory a	rrest,		Approximate Interval Between Onset and Death
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.O. Box 6	ath certif attending for use a	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal death		ic pregnancy r (specify)	,			ate of deliv	very Day Year
Δ.	es that the de igned by the a be detached t	y Ph	Part II. Other significant conditions	contributing to death bu	it not resulting in	the underlyi	ng cause giv	en in Part I.	23e. Did	tobacco use cor	ntribute to	the cause of death?
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Vita	Physician: r this certific ral director,	Be	25. Was case referred to medical examiner?	Hospital:			Oth	26. Place of Dear				
ō	Phy rthis rald	. To	1 ☐ Yes 2 No 27. Manner of Death	28a. Date of Injur	y 28b. Ti	me of	DOA Other	4 LI Nursing He		dence 6 🗷 thow injury occu		ity) hospice
sion	Attending Fr death. ector: After by the funers	ation	1 XNatural 5 ☐ Pending investigation		Year) In	jury M		k? Yes 2 ☐ No				
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Strict of the course of the co										anner as s	stated. to the cause(s)	
	To the within 2 To the complet	Σ	29b. Signature and title of certifier	100			29c. Licenson	number		29d. Date sign		
	\		30. Name and address of person who	.,	eath (Item 23a) (7	vpe, Print)				0 Crose	14	2007
	10x1		AARN J. CHARLES	wn 6701	N. Charle		NOT MAL	MO 212	104			
	State 31. Date filed (Month, Day, Year) 32. Begistrar's Signature 31. Date filed (Month, Day, Year) 32. Begistrar's Signature											

07-07707 Rodney Motes Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2007 33453 Certificate of Death 1- For State Reg. No Registrar 2. Date of Death Decedent's Name (First, Middle, Last) Physician/ October 2, 2007 1750 hrs Rodney G. Motes Medical Examiner 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Baltimore N/A 3800 W. Belvedere Ave If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 7. Age (In yrs. last birthday) 5 Social Security Number **Funeral** oreign Months Days Hours July 30,195 4 Country) Director 53 213-60-0122 1 X M Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location Yes 2 No or 28a-f show s 23a or 28a-f show e notified at once. Baltimore Maryland N/ADirector 10g. Citizen of What Country? 10f. Zip Code 21215 10e. Street and Number USA Belvedere Ave#709 3800 W. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, Funeral 12. Was Decedent Ever in U.S. 11. Marital Status Baltimore, MD 21215-0036
permit. Pages I and 2 should be filed within 72 hours after death wit
Department of Health and Mental Hygiene.
Important: I friem 27 is marked other than "natural", or items 3
injury or other trannantic event, the Medical Examiner must be a White, etc. Armed Forces? Never Married 2 Married Yes 2 x No Black Specify: Yes 2 X No specify: If Yes, Give Year 4 X Divorced ģ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Private Industry Laborer 12th grade 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Christine Little Be Gordon Motes 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) ို Panacea Court Pikesville, Md 21208 Sister Greta Armstrong/ 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition crematory or other place) 1 Burial 2 Cremation 3 Removal from State Baltimore, Md Greenmount Cemetery 4 Donation 5 Other Specify: 22. Name and Address of Facility Chatman-Harris Funeral Home 21. Signature of Funeral Séprice Licensee 5240 Reisterstown Rd Baltimore, Md 21215 alli 24a. Part I Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician Between Onset and failur. List only one cause on each line Death 'Medica Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions. Due to (or as a consequence of): if any, leading to immediate Examiner cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last executed and Physician/Medical X UNPENDED AMENDED Items: 23a & 27 per MEO G-872 10/19/07 reb attending physician or use as the burial certificate be 23d. Date of delivery Box 68760 23c. If yes, outcome of pregnancy IF FEMALE: Year Month Day 23b. Was decedent pregnant in the 3 Ectopic pregnancy Fetal death Live birth past 12 months? Pregnant at time of death 5 Other (Specify) The law requires that the death 1 Yes 2 No 9 Unknown g Unknown 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. signed by the detacher Part II. Other significant conditions Division of Vital Records, P.O. Yes 2 No 3 Probably 4 V Unknown ğ Completed 24a. Was an 24b. Were autopsy findings available After this certificate has been a meral director, page 2 should prior to completion of cause of autopsy death? performed? 2 No 1 🗸 Yes 1 🗸 Yes 2 26.Place of Death (Check only one) To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this confir-25. Was case referred to medical Be Hospital: Nursing Home 5 Residence 6 V Other: Scene DOA Other4 ER/Outpatient 3 Inpatient 2 1 🗸 Yes No 28d. Describe how injury occurred 28c. Injury at Work? 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death Certification: 1 X Natural Yes 2 No Pending Director: A Investigation Accident 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Could not be Suicide determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Wedical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier October 3, 2007 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Ana Rubio MD. 31. Date filed (Month, Day, Year) 32 Registrar's Signature State MARIE

Registra

2007

CARLOW

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 = For State Registrar		epartment of Health and l	Mental Hygier	- 211117	33454
			Decedent's Name (First, Middle, Last,			2. Date of Death		3. Time of Death
	Physici /Medio	765	Stephen M	Kolaenko		October	10,3007	6:05pm
	Examin		4a. Facility Name (If not institution, give		4b. City, Town, or Location of Deat	n	4c. County of Death	20.00
	Funeral		5. Social Security Number 6. Se:		(ay) If Under 1 Year If Under 24 Hrs		9. Birthola	ace (State or Foreign
	Director		217-30-1400	M 2□ F 9/ Yrs	s. Months Days Hours Min.	9 (Month, Day, Yes	16 UKr	CAINE
	and w		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town o	r Location		10	d. Inside City Limits
	death with the Maryland me 23a or 28a-1 ehow	to	MD Balton	nce.	udalk			1 Tes 2 10
	or 28s	irec	10e. Street and Number		10f. Zip Code	10g.	Citizen of What Countr	ry?
	ath wi	by Funeral Director	208 Colgate	Avenue	21222		ukrain	VE
	Items	une	11. Marital Status 1 Newer Married 2 Married	12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No	 Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer 	pecify Yes or No- o Rican, etc.)	14. Race - America Black, White, et	
5-0036	s 1 and 2 should be filed within 72 hours after death with the Marylar of Health and Mental Hygiene. Itam 27 is marked other then "naturel", or Itema 23a or 28a-1 show than traumatic event, the Medical Examinar must be putilled at	by	3 ₩idowed 4 □ Divorced	If Yes, Give Year or Dates:	1 ☐ Yes 2 ☑ No Specify:		Specify: WK	ite
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121	within ene. then	mp	Elementary/Secondary (0-12)	College (1-4or 5+)	fe. DO NOT use retired)	n	A.	1
d 21	filed Hygie other	Be Co	17. Father's Name (First, Middle, Last)		MAChinist 18. Mother's Nar	me (First, Middle, Maid	ncricuv U len Sumame)	CN CO.
<u>la</u> n	Aental Aental rked (To B	UNKNOWN		wkr	NUM		
Maryland	12 should be filed within 7 h and Mental Hygiene. 7 ie marked other then "r raumetic event, the Mad		19a. Informant's Name/Relationship (Ty	pe, Print) 19b. M	lailing Address (Street and Number or Ru	The state of the s	y or Town, State, Zip (Code)
-	fealth im 27 har tr		-lulia Waters	- daughter 22	808 Plain Held isposition (Name of	Rd. Duw	dork, mb.	21222
lor	nt of h		20a. Method of Disposition 1 Burial 2 Cremation 3 P	emoval from State cemetery,	crematory or other place)		Location - City or Tow	vn, State
Baltimore	permit. Pages Department of Important: If it any njury or ones		4 □ Donation 5 □ Other (Specify) 21. Signatur → Funeral Service License		Drews Cemckery 10- 22. Name and Address of Facility 0	Abley - As	LANGEL EL	to cal Hame
ñ	Deports Imports any nj		MIHALK	\supset	PA. 2134 Willow	SDrING	0 1	222
			23a. Part1. Enter the disease, or complishock, or heart failure. List only or	cations that caused the death. Do not no cause on each line.	enter the mode of dying, such as cardiac	or respiratory arrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death)	Conge	the Neart Falls	1re		Onset and Death
1	/Medical Examiner		resulting in dealthy	Due to (or as a consequence of):				f.)
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8760,	cate be executed physicien and the burial-transit		resulting in death) cast	Due to (or as a consequence of):				/
687	ificate be g physicie as the bur	edlcal						
Вох	th cert ending	an/M	230. Was decedent pregnant	3c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death	3 ☐ Ectopic pregnancy		23d. Date of deliver	,
.O. E	The law requires that the death certific sie has been signed by the ettending p page 2 should be detached for use as	Completed by Physician/Med	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at time of death 9☐ Unknown	5 Other (specify)		Month D	Day Year
σ.	that the ed by detac	/Ph	Part II. Other significant conditions cor	stributing to death but not resulting in th	ne underlying cause given in Part I.	23e. Did tobacc	o use contribute to the	cause of death?
Division of Vital Records,	quires in sign uld be	ed by				1 ☐ Yes	2 No 3 Proba	bly 40Unknown
OOa	law re as bee 2 sho	piet				24a. Was an autopsy	24b. Were autop:	sy findings available
Œ.	The page	Сош				performed		pletion of cause of 2☐ No
Vita	Physician: this certific ral director,	Be	25. Was case referred to medical examiner?	lospital:		ath (Check only one)		
o	Phys or this oral di	5.7	27. Manner of Death	1 ☐ Inpatient 2 ☐ ER/Outpa 28a. Date of Injury (Month, Day Year) 28b. Tim		lome 5 ☐ Residence		
ion	ath. r: Afte	atlor	1∰Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year) Inju	ry Work? M 1 ☐ Yes 2 ☐ No			
i≼i	or Atte	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm building, etc. (Specify)	, street, factory, office	28f. Location (Street City or Town, Str	and Number or Rural	Route Number,
۵	pital o	S	29a. Certifier 1₩ Certifying Phys	inima. Ta the best of multipouted as a			7.5	
	To the Hospital or Attending Physician: The law within 24 bounts after death. To the Funeral Director After this certificate has completely filled in by the funeral director, page 2	ledicai		ner: On the basis of examination and/o and manner stated.	eath occurred at the time, date and place or investigation, in my opinion, death occu	rred at the time, date a	and place, and due to t	the cause(s)
	To th within To th comp	¥.	29b. Signature and title of certifier		29c. License number	29d. I	Date signed (Month, D.	ay, Year)
			>		73757	3	Detober 1	1, 2007
	2		30. Name and address of person who co	100		1 1	17 2113	,
	Sta	te	31. Date filed (Month, Day, Year)		IN St. Keistra	Tem IV	V CUS	0
	Registr		OCT 1 8 2007	32. Registrar's Signature				

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State Registrar Amend #5, perFH, g873, 11/2/07 TT Certificate of Death 1. Desedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** 1anes 2007 Maro /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner West Hills Moad baltimore 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Months Days Hours Director maryland Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heatth and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Director altimore 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code West Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 2 No 1 ☐ Yes Specify 2 ack 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) emino 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be idhnson Iliam 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Hills boad, Butimore MO 21229 avid Jones West 20b. Place of Disposition (Name of cemetery, crematory or other place) thedral 10.20.07 Baltimore, MD 22. Name and Address of Facility Toughn C. Greene funcial Service Cathedral 21. Signature of Funeral Service Licensee 51 Baltimore National Pike, Baltimore MO B1229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate
Interval Between
Onset and Death

H Q COUS Immediate Cause (Final disease or condition resulting in death) **Physician** Due to (or as a consequence of): /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine burial-transit requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760 attending physician Physician/Medical as the b IF FEMALE: for use If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 Ø No Month Year 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a detached t 9□Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, ģ 3 Probably 4 ☐ Unknown cate has been siç page 2 should b 1 ☐ Yes 2 ☐ No Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate has 2 No 1∐ Yes Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 1 ☐ Yes S No 1 Inpatient 2 ER/Outpatient 3 DOA မ 5 Residence 6 ☐ Other (Specify) After this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: To the Hospital or Attending I within 24 hours after death.
To the Funeral Director: After Natural

Accident 5 Pending Injury 1 ☐ Yes 2 ☐ No Investigation filled in by the 6 ☐ Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 39, Name and address of person who completed cause of death (Item 23a) (Type, Print) CHARLES MADHU CHARLES MD 2120L Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

OCT 1 8

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 33456 Reg. No. Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** Month 2:30 PM inder 10 14 0 0 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner LONG GREEN GENESIS BALTTMORE
If Under 1 Year | If Under 24 Hrs. N/A7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** Months Days Hours 1 □ M 2√√F 91 Yrs MD 214-07-8786 Director 10 15 15 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show injury or other traumatic event, the Medical Examiner must be notified at MD 1 Yes 2 □ No N/A Baltimore Funeral Director 10g. Citizen of What Country? 10e Street and Number 10f. Zin Code ö 238 4422 Old York Road 21212 USA Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. or Items 11. Marital Status within 72 hours after 1 Yes 2 No
If Yes, Give X
Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. þ 3 → Widowed 4 Divorced Black "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) llth U.S. Public Health N/ADietician 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be fill ment of Health and Mental H tant: If item 27 is marked ott Be Nehemiah Hopkins Catherine 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ellsworth L.Hopkins-son 4422 Old York Road Baltimore, MD 21212 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition Date 20c. Location - City or Town, State 1 XX urial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department o Important: If sny injury or once. 10/20/2007 Salem MD * 4 □ Donation 5 □ Other (Specify) Mt. Pleasant Church 21. Signature of Funeral Service Licensee 22. Name and Address of Facility MARCH FUNERAL HOME-EAST H lady 21202 Baltimore, MD wan 1101 E. North Avenue 23a. Part1. Enter the disease, or complications that caused the death. Do ngt enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Demento /Medical Due to (or as a consequence of): Examiner tailu/R Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner physicien and the burial-transit J. Postary Due to (or as a consequence of) Box 68760. Physician/Medical as IF FEMALE: esn esn 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregpant 3 DEctopic pregnancy ò in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. the detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Division of Vital Records, peq 2 2 No 3 Probably 4 Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

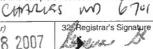
1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy performed? 2 No 1 Yes Be 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 2 🗷 No 4 Nursing Home 5 Residence 6 Other (Specify) P 1 🗌 Yes 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After (Medical Certification: 1 Natural 5 Pending Injury death. 1 ☐ Yes 2 ☐ No investigation after death Director: 2 Accident the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 - Homicide To the Hospital within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 00064788 MID 10 ٥ 30. Name and address of pers in who completed cause of death (Item 23a) (Type, Print) MT. ROYAL AUE, BALTIMORE, MT. IJA SHARMA 1600 w. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 8 Registrar

State Registrar

AMON J. 31. Date filed (Month, Day, Year) OCT 1 8 2007

29b. Signature and title of certifier



and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

N. Chris of TOWSON MO ZIZOY

29c. License number

29d. Date signed (Month, Day, Year)

OCTOBER 12 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 06:31 AM Winston Roberts 13 2007 OCTOBER 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death AGNES BALTIMORE SAINT HOSPITAL If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year)
Nov. 2, 1928 Social Security Num 230-30-3808 6. Sex Birthplace (State or Foreign Country) Days Months XXM 2□F 78 VA Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County MD Baltimore 1 X Yes 2 No 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 3330 Wilkens Avenue 21229 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 █No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. African American 1 □ Never Married 2 □ Married 1 ☐ Yes 2 🔀 No Specify: 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working unk life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) únk 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) unk 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Freida Jones / Guardian 10 N. Calvert Street; Baltimore, Maryland 21201 Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Mount Zion Cemetery 10/18/2007 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Wylie Funeral Home, P.A. 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 638 N. Gilmor Street; Baltimore, Maryland 21217 comes 23a. Part1. Enter the disease, or commendations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only the cause on each line. Immediate Cause (Final disease or condition resulting in death) VENTRICULAR FIBRILLATION ONE HOUR. Due to (or as a consequence of): ISCHEMIC COLITIS 2 WEEKS Due to for as a consequence off: CARDIOMYOPATHY 3 YEARS Due to (or as a consequence of): 3 YEARS. INSUFFICIENCY RENAL 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 4□Pregnant at time of death 5 ☐ Other (specify) ☐ Yes 2 ☐ No 9□Unknown 9 I Inknown 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

Physician /Medical Examiner

The law requires that the death certificate be executed

Records, P.O. Box 68760

Division or Vital Hospital or Attending Physician: **Physician**

/Medical

Examiner

10a. State

Funeral

Director

items 23a or 28a-f show ner must be notified at

"natural", or iten edica Examiner

tem 27 is marked other

Director

Funeral

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Completed

Be

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

Baltimore, Maryland 21215-0036

Examine that initiated events resulting in death) Last attending physician and for use as the burial-trar

Physician/Medical

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Completed

Be

P

Certification:

Medical

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury

5 ☐ Pending investigation

6 ☐ Could not be

determined

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. Was an performed 2 **☑** No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 28d. Describe how injury occurred

28a. Date of Injury (Month, Day Year) 28b. Time of

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

25. Was case referred to medical examiner?

1 Yes 2 No

27. Manner of Death

2 Accident

3 ☐ Suicide

4 Homicide

1 Natural

29c. License number P 21800 29d. Date signed (Month, Day, Year) OCTOBER 13,2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MATHEW PULTCKEN, 900 5 CATON AVE, BALTIMORE, MD

2007

31. Date filed (Month, Day, Year) State OCT 1 8 32. registrar's Signature

Registrar DHMH 17 Rev 1/2001

To the Hospital or within 24 hours aft To the Funeral Di completely filled in

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiens 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2 Date of Death HOMAS **Physician** SAWYER OCTOBER FOOS /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner LMORE HOSPITAL BALT N/A HARBOR If Under 1 Year If Under 24 Hrs. Months Days Hours Min. July 12 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1⊠M 2□F 216-34-8645 70 Yrs. MD Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State Item 27 is marked other than "naturel", or Items 23a or 28e-f show other treumatic event, the Medical Examenar must be a citibed at 1 ☐ Yes 2 ☑ No Director Baltimore Maryland Anne Arundel 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 21226 USA 212 Sycamore Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Completed by White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Construction Carpenter 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: if Item 27 is marked oth any injury or other treumatic event otte. 17. Father's Name (First, Middle, Last) Be Sawyer William D. Lillian Rice 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Martha J. Sawyer (spouse) 212 Sycamore Road, Baltimore, MD 21122 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Oct. 18 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Metro Crematory Inc. Baltimore, Maryland * 4 □ Donation Other (Special 2007 22. Name and Address of Facility 21. Signature of Juneral Ser Stallings Funeral Home. P.A. 3111 Mountain koad, Pasadena, MD 21122 Approximate Interval Between Onset and Death 23a. Part1. Enter the disea 1, or complications that shock, or heart failure. List only one Suse on each used the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, th line. Immediate Cause (Final **Physician** Preumonia resulting in death) /Medical Due to (or as a consequence of): Examiner Ventri cu Sequentially list conditions, farry, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner The law requires that the death certificate be executed burial-transit Artery and that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical as the attending IF FEMALE: use 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy lor Day Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No be detached the 9 Unknown 9 Unknown δ signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? igilzic 2 No 3 ☐ Probably 4 ☐ Unknown plnods 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has the funeral director, page 2 autopsy performe certificate 1 🗌 Yes 1 ☐ Yes 2 ☐ No 2 No Hospitel or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 No 1 Inpatient Certification: To 2 ER/Outpatient 3□ DOA this 27. Many r of Death Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation hours after death unerel Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 🗌 Homicide within 24 hours a To the Funerel C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Dedagat MD House office 29b Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) officer RES 001 OCTOBER 17 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HARBOR HOSPITAL 3001 SHANOVER STr., BALTIMORE, MD, 21225 BEDATAT 32 Registrar's Signature 31. Date filed (Month, Day, Year) State 18 Registrar

DHMH 17 Rev 1/2001

07-07817 William D. Stanley

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2007 33460

Posponition Depresent plant Maria Labor			Registrar Certificate of Death										
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Director The Court South Private Part and South South Private Part and South South Private Part and South South Private Part and South South Private Part and South South Private Part and South Private Part			4a. Facility Name (if not institution, give street and number) 4b. City, To	own, or Location of Death 4c. County of Death									
2 Social Security Number 2 Security Number				een Harford									
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Registrar UG 1 8 ZUU Village of Village -			007 4 0 0007										

State of Maryland / Department of Health and Mental Hygiene 0 7 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death OCTOBER **Physician** SCHAPIR0 2007 12:45P M BERNICE /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Center Towson Baltimore 8. Date of Birth Office of 19/19/28 Birthplace (State or Foreign Country)
 NY 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex **Funeral** 1 □ M 2 🙀 F Months Days Hours Min. 79 122-18-4770 Director Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medi-al Examiner must be notified at once. 10a. State 10b. County 1 ☐ Yes 2 No BALTIMORE BALTIMORE Funeral Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 21208 8002 BRYNMOR COURT 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 Yes 2 No
If Yes, Give X
Year or Dates: 1 ☐ Never Married 2 ☐ Married WHITE Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Completed by Specify. 3 Nidowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER AT HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be BERNSTEIN KAGNER SARAH SIDNEY ۵ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8209 PUMPKIN HILL COURT - BALTIMORE, MD 21208 WILLIAM SCHAPIRO 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ¼ Burial 2 □ Cremation 3 □ Removal from State 10/17/2007 OWINGS MILLS. MD HAR SINAI CONG. 4 Donation 5 ☐ Other (Specify) SOL LEVINSON & BROS.. INC. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) SEPSIS **Physician** /Medical Due to (or as a consequence of) **Examiner** RUPTURED TYPE III THORACOABDOMINAL Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit AORTIC ANEURYSM Division or Vital Records, P.O. Box 68760亿分 Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown neral Director: After this certificate has been signed by the atter filled in by the funeral director, page 2 should be detached for it Month Day 4☐Pregnant at time of death 5 Other (specify) 9☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 1 Yes 1☐ Yes 25. Was case referred to medica Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of Injury 3 🗆 DOA 1 Tyes 2 ER/Outpatient Medical Certification: To 28h. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director:
completely filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and te of certif D24034 25 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TIMOTHY LOW. M. D 7601 OSLER DRIVE TOWSON, MARYLAND 21204 strar's Signature 31. Date filed (Month, Day, Year) 32. State Registrar 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#5perINF. G887, 1/7/09 WS
State of Maryland 7 Department of Health and Mental Hygiene Reg. No 2007 For State Registrar Certificate of Death 3. Time Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** October 11:30 P.M 14, 2007 **GEORGE** DULANEY SOLTER /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Social Security Number Gilchrist Center Baltimore Towson If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** Days 1 X M 2 □ F Maryland 86 15. 1920 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits the Maryland 10b. County 10a. State permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Be Completed by Funeral Director Baltimore Maryland Towson 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 1055 W. Joppa Road #753 21204 U.S.A. 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Yes 2 No
If Yes, Give
Year or Dates: 1942–46 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 Nidowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Attorney/Judge Law 5+ years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) George Alexander Solter Christie Dulanev 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3220 Benson Mill Road, Date Maryland 21155 Upperco. J. Ritchie Solter (son) 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 MCremation 3 ☐ Removal from State 10-17-07 Baltimore, Maryland 4 □ Donation 5 □ Other (Specify) Green Mount Cem. Crematory 22 Name and Address of Facility
Mitchell-Wiedefeld Funeral Home, Inc
6500 Vork Road Baltimore, Maryland 21. Signature of Funeral Service Licensee ? Mitchell 21212 art1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, nock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** ONUMNIE days disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Schemic Cordingopatrio Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-tra Due to (or as a consequence of): physician at the burial Division or Vital Records, P.O. Box 68760, Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Year Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) signed by the a 9□Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has birector, page 2 s autopsy perform 1 Yes 2 2 No or Attending Physician: 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Hospital: 3 DOA 4 Nursing Home 5 ☐ Residence 6 Nother (Specify) have 1 ☐ Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient Certification: To this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After Injury 1 Natural 5 ☐ Pending investigation М 1 ☐ Yes 2 ☐ No death. thours after death.

uneral Director: A
ely filled in by the fu 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 4 Homicide within 24 hours at To the Funeral D completely filled in Hospital 1 XCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) rles St Towson ', cha HARON J COMPLIES 6701 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registrar 8 2007 DHMH 17 Rev 1/2001

To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director; After th completely filled in by the funeral

ENOI egistrar's Signature 31. Date filed (Mont), State 2007 Registrar DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifie

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No 2007 33464 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year Month **Physician** Eula Josephine Truss **2**5₽[™] 2007 Oct 10 11 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Joseph Richey Hospice n/a Baltimore If Under 1 Year | If Under 24 Hrs. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** Months Days Hours 239-60-0918 65 10/09/1942 Director NC Usual Residence of Decedent e filed within 72 hours after death with the Maryland al Hygiene.

other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☑ Yes 2 ☐ No iral", or Items 23a or 28a-f sh Examiner must be notifled Director MD n/a Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 201 N. Washington Street #910 21230 United States Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 [XNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Completed by Specify: Black 3√ Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation traumatic event, the Medical (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Healthcare nurse 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be marked Douglas R. Whitehead Evelyn Crudup 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Toyne Truss/son S. Augusta Avenue, Baltimore, MD 21229 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State ò Zion Cemetery 10.20.07 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Chatman-Harris Funeral Home 21. Signature of Funeral Service Libensee 5240 Reistertown Rd, Baltimore, MD 21215 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence Examiner Se pentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence or): Examiner be executed Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by Records, 1 🗌 Yes 2 No 3 ☐ Probably Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an perform Vital 25. Was case referred / medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 ther (Specify) 2 No 2 ER/Outpatient 3 DOA 1 ☐ Yes Certification: To ō 28a. Date of Injury (Month, Day Year) 27. Manper of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending Division 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death Director: 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) completely within 2 and manner stated. 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

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2007 33465

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Exami		Frissell Ivory Townes Frissell N Townes 4a. Facility Name (If not institution, give street and number) 4b. Cit	ity, Town, or Location of Death	40	c. County of Death
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	o Be	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Add	dress (Street and Number or	Rural Route Number,	City or Town, State, Zip Code) 2121
should I and Mer 7 is mar	ř	Jack Jack Jack Jack Jack Jack Jack Jack	Liberty Heid	hts Ave.	Baltimore MD c. Location - City or Town, State
nd 2 sho salth and em 27 is raumati		20a Method of Disposition		Date 20	c. Location - City or Town, State
Daltilliote, MID 2 12 10-00-00 permit. Pages 1 and 2 should be filled within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", injury or other traumatic event, the Medical Examiner.		1 X Burial 2 Cremation 3 Removal from State Trinity Ce		22.07	Dundalk, MD
Deficiency of permit. Pages 1 Department of F Important: If injury or other		4 Donation 5 Other Specify:			rris Funeral Hom
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		237 rt i. Enter the disease, or complications that caused the death. Do not enter the m	mode of dying, such as cardiac	or respiratory arrest,	shock, or heart Approximate Interval Between Onset and
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		or condition resulting in death) Due to (or as a consequence or).			
	<u>ہ</u>	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):			
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Box 687(death certificate the attending pled for use as the	3.	past 12 months? 4 Pregnant at time of death 5 Other	r (Specify)		lij.
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Division of Vital Records, tat or Attending Physician: The law requires after death. In Director: After this certificate has been so in he, the finered may be a should it he, the finered finered at should it.			1 Yes 2 Y No	unk	
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VISI or Att fler de olirect	9	2 Accident Investigation 28e. Place of Injury - At home, farm, street,		or Town Sta	th Ave. Baltimore, MD
Divisior Hospital or Attend 24 hours after death Funeral Director:		1 Natural 5 Pending Investigation 28e. Place of Injury - At home, farm, street, 4 Homicide 4 Homicide 28e. Confifer			
Hos 4 h Fun			ed at the time, date and place, on, in my opinion, death occurr	ed at the time, date ar	nd place, and due to the cause(s)
To the I within 2 To the I	completely	and manner stated.	29c. License number		29d. Date signed (Month, Day, Year)
F 3 F 3	1	29b. Signature and title of certifier	O.C.M.E.	İ	October 6, 2007
/			U.U.IVI.E.		
& OCA	ΛB	30. Name and address of person who completed cause of death (Item 23a)	Dean Street Politimer	MD 21201	
		Mary G. Ripple MB. Bopas, Chief Mary	Penn Street, Baltimore	5, IVID Z 1201	
	Sta	te 31. Date filed (Month, Day, Year) 32. Registrar's Signature	ه فيم		
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 33466 Reg. No [] Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** Gwendolyn Berry lownlev-Ineresa 7:15 AM October 13 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner NA Sinai of Baltimore Baltimore Hospital 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🖫 F Months Days Hours 219-60-8853 Director 02-08-1951 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits show Examiner must be notified at Cecil Mo 1 ☐ Yes 2 No Director Deposit or 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 22 21904 USA items 23a Funeral Street permit. Pages 1 and 2 should be filed within 72 hours after death \text{Department of Health and Mental Hygiene.} Important: If item 27 is marked other than "natural", or items 23 any injury or other traumatic event, the Medical Examiner must any injury or other traumatic event, the Medical Examiner must once. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 Mo If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1□Yes 2No þ Specify. 3 Widowed 4 Divorced Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Swends 171 Elementary/Secondary (0-12) College (1-4or 5+) 1272 Worker Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 Jackson lownley 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Port Keuin Race lownles posit 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 11 Burial 2 ☐ Cremation 3 Removal from State Berkley 4 ☐ Donation 5 ☐ Other (Specify) Cemetary 10/20/2007 Darlington, Name and Address of Facility Chatman Harris 4210 Belair 21. Signature of Funeral Service Licenses Har ller 1D 21206 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on such line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician betui disease or condition resulting in death) /Medical consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed physician and s the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical as t attending p IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 ☐ Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 4☐Pregnant at time of death been signed by the a should be detached 2 🗆 No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tes 3 Probably 4 Unknown ancer 24a. Was an 24b. Were eutopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No After this certificate has funeral director, page 2: autopsy performed To the Hospital or Attending Physician: 25. Was case referred to medical Medical Certification: To Be 26. Place of Death Check onl one examiner? 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Nnpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Natural 28a. Date of Injury 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation (Month, Day Year) s after death. death. 1 ☐ Yes 2 ☐ No 2 Accident the 1 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide within 24 hours at To the Funeral D Exertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) OCTOBER 13, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Abba Are Baltimore Mol 2/2/5 West belvedere 38. Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

OCT 1 8 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1- For State of Maryland / De Registrar	partment of Health and ertificate of Death	Mental Hygie		33467	
	Physic	200	1. Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year	3. Time of Death	
	/Medi		JACQUELINE GAY THOMAS			2007	4:25 A M	
l.	Examir	ner	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Dea	ath	4c. County of Death	1 -	
	ra Jana 1		Genesis Eldercare 5. Social Security Number 6. Sex 7. Age (In yrs. last birthda	Severna Park		Anne Arundel		
Sal	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda 214-22-6790 1 M 2 F 80 Yrs.	y) If Under 1 Year If Under 24 Hr Months Days Hours Mir		9. Birthp	place (State or Foreign ntry) NY	
	7		Usual Residence of Decedent		00-03-192	27	NI	
	yland		10a. State 10b. County 10c. City, Town or	Location		1	Od. Inside City Limits	
	e Ma	ctor	MD Anne Arundel Glen B	urnie			1 ☐ Yes 2√ No	
	or 28	Sire.	10e. Street and Number	10f. Zip Code	10g.	Citizen of What Cour	ntry?	
	ath w	Funeral Director	603 Marshall Road	21061		U.S.A.		
	er de Items	nue	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	 Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Pue 	Specify Yes or No- rto Rican, etc.)	14. Race - Americ Black, White,		
36	rs aft	by F	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	1 ☐ Yes 2 No Specify:		Specify: Whi		
21215-0036	72 hours after death with the Maryland "natural", or Items 23a or 28a-f show salical Examinat for mathed at	ed		edent's Usual Occupation	166	. Kind of Business/Inc		
215	C 0	Completed	(Specify only highest grade completed) (Gi	re kind of work done during most of wo DO NOT use retired)	orking	o. Kind of Odsinessyllic	Justry	
212		E		itress	ĺ	Restauran	t	
p	be filed vital Hygie of other tevent, In	Be (17. Father's Name (First, Middle, Last)	18. Mother's Na	me (First, Middle, Maid	den Sumame)		
Na	should be nd Mental marked o umatic eve	0	George Thomas	Chris	tine Spicer	c		
Maryland	S D E E			iling Address (Street and Number or R			Code)	
	is 1 and 2 of Health a Itam 27 is other trai			1 Rockhold Drive	Deale, N			
0				ematory or other place)		. Location - City or To		
Baltimore,	t. Pa rtmer rtant:			ake Cremation 10-		tevensvill		
Ba	permit. Page Department of Important: If any injury or		2000 100 NWC 1479		n Burnie, N	4D 21061	emation Srv	
Ĭ,	Physician /Medical Examiner	ılner	23a. Part 1. Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury the initial sequence or injury)	l infarc	1	/	Approximate Interval Between Onset and Dea/th	
	orificate be executed ing physician and e as the burial-transit	Medical Examiner	resulting in death) Last Due to (or as a consequence of): d.				- A	
.O. Box	that the death certific ed by the attending p detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3	□Ectopic pregnancy □ Other (specify)		23d. Date of delive Month	ry Day Year	
ords, P	v requires that been signed b should be deta	þ	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacc	co use contribute to th		
	The lay	Completed			24a. Was an autopsy performed 1 Yes 2	? prior to con death?	osy findings available inpletion of cause of	
\frac{1}{5}	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner? 1 Ves 2 TAILS Hospital:	Othor	ath Check only one			
ō	Attending Physic death. actor: After this by the funeral di	ition: To	1	7	dome 5 Residence 28d. Describe how in)	
Divis	To the Hospital or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	Certification:	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)		28f. Location (Street and Number or Rural Route Num City or Town, State)			
	To the Hospital or within 24 hours afte To the Funeral Dir completely filled in 1	edical (29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, deal of the best of the best of my knowledge, deal of the best of	th occurred at the time, date and place nvestigation, in my opinion, death occu	e, and due to the cause urred at the time, date a	e(s) and manner as sta and place, and due to	ated. the cause(s)	
	To the within 2 To the complet	Me	29b. Signature and title A entifier	29c. License number		Date signed (Month, L		
•	and the state of t			D 5070	45 10	-16-a	007	
6		(30 Name and address of person who completed cause of death (ttem 23a) (Type Second Torkied)	erans Huy N	lillerevi	U MO	21108	
	Sta Registra		31. Date filed (Month, Day Year) OCT 18 2007	parti O			. 0	

07-0	8051

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Pedro Inicho	Tu		1- For State	State of Maryl		oartment o <i>ertificate o</i>		and M	lental H		Reg. No.	20	007	3346
Phys		an/	1. Decedent's Name (First, Mic							Date of Dea Month	ath Dav	Year	3. T	ime of Death
Medical Exa	amı	ner	Pedro Inich 4a. Facility Name (if not institu				4b. City, Town	or Loca	tion of Death	October 7	15, 200	County of D		503 hrs
q			25 1/2 N. Fulton Ave	-	J		Baltimore							
Fune			5. Social Security Number 215–16–1774	6. Sex	7. Age (In yrs	s. last birthday)	If Under 1 \	_	Under 24Hrs lours Min	_	irth (MM/[OD/YYYY) 9	. Birthpla Country	ce (State or Foreign
Direc	tor			1 ^{XX} M 2 F		84 Yr		ays	louis IVIII	Oct.	23, 19	922		MD
Aug		ł	Usual Residence of Decedent 10a. State 10b. Count	ty	10c. C	ity, Town or Loca	tion						10d	. Inside City Limits
and	nce.	ē	MD				Balti:	nore					1 3	X Yes 2 No
the Maryl	tified at o	Director	10e. Street and Number 25½ N. Fulto	n Avenue			10f. Zip Cod	21	223		10g. Citiz	en of What U	Country? SA	
, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland eath and Mernal Hygiers with the Maryland frem 27 is marked other than "natural", or items 23a or 28a-fish	er must be notified at once.	y Funeral		Married Armed II 1 X Yes Divorced If Yes, Give Yes	2 No	If Y	as Decedent of res, specify Cu	ban, Mex	kican, Puerto	pecify Yes or N Rican, etc.)		14. Race - A White, e Africa : Specify:	tc.	Indian, Black, rican
nours a	xamir	ed by	15. Decedent's Education (S			16a. Decede	nt's Usual Occu nost of working				16b. K	ind of Busin	ess/Indus	stry
36 in 72 h	lical E	plete	Elementary/Secondary (0-1: 12	2) College	1-4 or 5+)	- dailing ii	_		drive		Ra1	timore	City	
d with	he Mc	Completed	17. Father's Name (First, Midd	lle, Last)			Derec			(First, Middle,			Olty	
21215-0036 ald be filed within 7 Mental Hygiene.	rent, i	Be		bert A. Tuck	er					cille Sco				
ore, MD 21215-0036 ss 1 and 2 should be filed within 72 hours after of Health and Mental Hygien 17. Ifficen 27 is marked other than "natural?".	or other traumatic event, the M. dival Examiner	2	19a. Informant's Name/Relatio							Rural Route Number, City or Town, more, Maryland 212				
S 1 S I S I S I S I S I S I S I S I S I	er tra	- 1	20a. Method of Disposition 1 X Burial 2 Cremati	ion 3 Removal t		b. Place of Disport crematory or of		cemeter	y,	Date	20c. L	ocation - Ci	ty or Tow	n, State
Baltimore, permit. Pages 1 at Department of Her Important: If the	or of		4 Donation 5 Other	Specify:	C	rownsville			~	22/2007		wnsvill	•	ryland
Balt permit Depart	inju.		21. Signature of Funeral Service	ce Licensee		22.1				lie Funer t; Baltir		-		1217
Physici		7	23a. Part I. Enter the disease, failure. List only one caus	or complications that	caused the dea	ath. Do not enter				•	•	•	A	pproximate Interval
/Medic / xamir	-		Immediate Cause (Final diseasor condition resulting in death)	se a <u>Hyperte</u>	nsive atl	nerosclero	tic card	LOV39	cular d	isons				Death
			Sequentially list conditions,	b										
		Examiner	if any, leading to immediate cause. Enter Underlying Caus (Disease or injury that initiated	se	a consequence	e of):								
My B B	ransit		events resulting in death) Las		a consequence	e of):								
o, e be executed	burial - transit	edical	X UNPENDED ##ENDED #72, perME, g873, 11/1/07 TT											
Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death.	or use as the	sician/M	IF FEMALE: 23b. Was decedent pregnant in past 12 months? 1 Yes 2 No 9 L	the 23c. If yes,	outcome of pr birth nant at time of	egnancy 2 Fe	etal death ther (Specify)		ctopic pregna	ancy	230	l. Date of de Month	livery Day	Year
O. I hat the ed by ti	be detache	by Phy	Part II. Other significant cond		to death but no	t resulting in the	underlying caus	se given	in Part I.					cause of death?
IS, P. quires th	pe [Chronic alcoho	olism						1 Ye				4 Unknown y findings available
Division of Vital Records, ra ager death. The faw requir and a start death. The precent Alter this certificate has been si	funeral director, page 2 should	Completed								auto	opsy orm <u>ed</u> ?	prio dea	r to comp	letion of cause of
ital iician: s certif	rector	a	25. Was case referred to medie examiner?	Hospital:	Inpatient 2	ER/Outpatien		ace of D Othe	eath (Check	only one)	Panida	nce 6 🗸	Othor: Co.	
of V g Phys fter thi	neral d	2	1 ✓ Yes 2 No 27. Manner of Death	28a. Date	e of Injury	28b. Time of		njury at \	T Traisii	28d. Describe			Julei. Sci	
ion tendin leath.	the fu	atio		ending vestigation	h, Day,Year)		1	Yes	2 No					
Division tal or Attenous after death	lled in by	Certification:	3 Suicide 6 Co			t home, farm, stre	et, factory, offic	e buildir	ng, etc.	28f. Location or Town,		nd Number o	or Rural F	Route Number, City
Divisior To the Hospital or Attend within 24 hours after death To the Funeral Director:	<u>e</u>	_	29a. Certifier 1 Certifying	Physician: To the be caminer: On the basis and manner	of examination									use(s)
5.85	S	ŝ	29b. Signature and title of certi		orareu.			ense nur	OCME	· · · · · · · · · · · · · · · · · · ·		Date signed		Day, Year)
			Theoder 1	U Keng	Mu	10)	0.	C.M.E.			Octo	ober 16, 2	2007	
Ø			 Name and address of person Theodore M. King, J 		ise of death (Ite ant Medica	,	111 Penn	Street,	Baltimore	e, MD 2120)1			
		-	31. Date filed (Month, Day, Yea	r) 32	egistrar's Sign	ature do	and the							
Reg	gist	ιeli	0CT 1 6	LUUI JANA	The Confession	-								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) Day 2. Date of Death Month **Physician** JOSEPH E. WRIGHT October 200 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner UNION MEMORIAL HOSPITAL BALTIMORE N/A If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) 2 21 1935 9. Birthplace (State or Foreign **Funeral** Min. Months Days Hours tXCXM 2 ☐ F 027-26-5417 72 Director Mass. Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 28a-f show r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at Director 1X Yes 2 No Mass N/A Boston 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 362 Blue Hill Avenue 02121 USA death \ Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2€ If Yes, Give Year or Dates: 2XNo Baltimore, Maryland 21215-0036 'natural", or þ 1 ☐ Yes 2 ☑ No Specify: Specify: 3X Widowed 4 ☐ Divorced Black Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12th N/A Bus Driver Department of Health and Mental Hygie Important: If item 27 is marked other any Injury or other traumatic event, the once. Bus Co 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 Joseph S. Wright Harriett Beane 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Stacey V. Salmond-daughter 4616 Crosswood Avenue Baltimore, MD 21214 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Mt. Hope Cemetery 10/20/2007 4 Donation 5 ☐ Other (Specify) Boston Mass 22. Name and Address of Facility 21. Signature of Funeral Service Licensee MARCH FUNERAL HOME-EAST 0 0 1101 E. North Avenue Baltimore, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause in each line. Approximate Interval Between Onset and Death ter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) **Physician** aw /Medical (or as a consequence of) Examiner Sequentiany list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine the Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 physician Physician/Medical attending p IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav 4□Pregnant at time of death 5 ☐ Other (specify) 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 4 Nanknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performed Yes 2 certificate 25. Was case referred to medical examiner? director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes Certification: To 1 Inpatient 2 ER/Outpatient 3□ DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide within 24 hours aft To the Funeral Di completely filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar

29b. Signature and title of certifie

31. Date filed (Month, Day,

8

and address of person who completed cause of death (Item 23a) (Type, Print)

MO

#82. Registrar's Signature

DHMH 17 Rev 1/2001

29d. Date signed (Month, Day, Year)

10

200

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Amend #18, perFH, C872, 10/22/07 TT Certificate of Death 33470 Reg. No 2 0 0 7 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Milford R. Woodson October 14, 2007 12:56 pM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Suburban Hospital Bethesda Montgomery If Under 1 Year | If Under 24 Hrs. 5 Social Security Number 8. Date of Birth (Month, Day, Year) 08/30/1939 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. 228-54-6241 1 ₩ M 2 🗆 F 68 VA Director Usual Residence of Decedent 10a. State 10b. County 10c, City, Town or Location 10d. Inside City Limits ns 23a or 28a-f show must be notified at MD Montgomery Rockville Director 1XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5901 Montrose Road 20852 USA death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Examiner Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or Ite 2 No 1 ☐ Yes 2 2 If Yes, Give Year or Dates: 1 Never Married 2 Married altimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 X No Specify ģ 3 Widowed 4 Divorced Completed Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Computer Sales Executive the Computer Sales 7 is marked other traumatic event, the 18. Mother's Name (First, Middle, Maiden Surname)

Lucille Ryland 17. Father's Name (First, Middle, Last) Be Merritt Woodson 2 Lucile 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5901 Montrose Road, Rockville, MD 20852 Milford R. Woodson II / item 27 other t 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Department of Important: If it any Injury or o once. Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 10/19/2007 Calvary Cemetery Norfolk, VA 21. Signature of Funeral Service Licens 22. Name and Address of Facility Porota (Charles L. 1501 East les L. Stevens Funeral home Inc. <u>East Fort Avenue, Baltimore, M</u>D 21230 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CANFORMMONAY **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner SUSTIM ONGAN MUUTI Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner THAMER AUTR RUPMINO the burial-tran Due to (or as a consequence of) Box 68760. attending physician for use as the burial IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy in the past 12 mor 4□Pregnant at time of death
9□Unknown Month Day Year 5 Other (specify) been signed by the s Ö 9 Unknown Δ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 1 | Yes 2 | No 3 | Probably 4 | Onknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy this certificate 1∐ Yes 2 3 10 director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 \sum Nursing Home 1 ☐ Yes 1 □-Inpatient Certification: To 2 ER/Outpatient 3 DOA 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury funeral 27 Manner Death 28b. Time of 28d. Describe how injury occurred (Month, Day 1 Wintural 5 Pending investigation 1 ☐ Yes To the Hospital or Attence within 24 hours after death To the Funeral Director; 2 ☐ Accident filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. 29c. License numbe 29d. Date signed (Month, Day, Year)

10/4/01

Woodson Sr

31. Date filed (Month State Registrar

EB

10mw Day, Year) 32. 18

8600

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2007 State Registrar Amend 20b, perFH, 0872, 10/23/07 TT Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** WILLIAM Month 13:10 PM OCTOBER-2007 /Medical Facility Name (If not institution, give street and number) 4c. County of Death Examiner salt Mo 12 hns Hoakins If Under 1 Year | If Under 24 Hrs. Social Security Number 6 Sex Birthplace (State or Foreign Country) **Funeral** Months Days Hours 8-36-4096 1**⊠**M 2□F **Director** Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show Examiner must be notified at 1X Yes 2 No Director MARYLAND 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A Funeral items 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 No ō Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: BLACK Completed by 3 Widowed 4 Divorced "natural", 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than the M Elementary/Secondary (0-12) College (1-4or 5+) 12 +HGRADE MANUFACTURING 7 Is marked other traumatic event, the 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 Is any Injury or other trauonce. YNNETTE 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 10/22/2007 1. Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ATONSVILLE, MA 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 5 minutes /Medical Due to (or as a consequence of): **Examiner** BRAIN INJURY Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transit VENTRICUL 1BPILLATION Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 ☐Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) been signed by the a should be detached 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 No 2 No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? funeral director. 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Hospital: 1 Inpatient Certification: To 2 ER/Outpatient 3□ DOA After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation Injury within 24 hours after death.

To the Funeral Director; A completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MEDICAL DOCTOR OCTOBER 14,2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

KELLY EPPS, JOHNS HOPKINS ITOSPITAL, LOO NORTH WOLFE STREET, BALTIMORE, MARYLAND 21287

32. Registrar's Signature

07-08053 Sharon Ella Wilbar Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2007 33472

		- For State					Certific	cate of	Death				F	leg. No.	-	0 0		0041
Physicia		1. Oecedent's Name (First, Middle, Last) 2. Oate of Oeath Month Day Year																
edical Examir		SHARON ELLA WILBAR October 15, 2007																
		4a. Facility Name (if		n, give stre	eet and nu	ımber)		4	b. City, Tov	wn, or Lo	ocation of	Death			County of C	Death		
		71 Neptune I	Drive				_		Joppa						arford			
Funeral		5. Social Security Nu	umber	6. Sex		7. Age (In	yrs. last bi	rthday)	If Under Months		If Under Hours	24Hrs. Min.	8. Oate of B	irth(MM/O		oreian		
Director		219-72-92	277	1 M	$2_{\mathbf{X}}$ F	49		Yrs.	Wichtins	Ouys	110015		Aug. 6	19	58	Coun	^{try)} Mar	yland
	- 1-	Usual Residence of															0d. Inside	
v any	- 1	10a. State	10b. County			10c	. City, Tow	n or Location	on								1 Yes	
and I show	5		Harfo	rd		J	oppa											2 📈
te Maryland or 28a-f show any fied at once.	Director	10e. Street and Num	nber						10f. Zip C	ode			i	10g. Citiz	en of What	Countr	y'?	
with the Maryland ns 23a or 28a-f sho be notified at once.		71 Nept	tune D	rive					2108	85				USA				
ath with the items 23a	era	11. Marital Status			. Was Oed Armed F	cedent Ever	r in U.S.		Decedent es, specify				cify Yes or N can, etc.)	0- '	14. Race - / White, e		ın Indian, E	Black,
~ 등 등 등	Funeral	1 Never Marrie		1	Yes	2 🗴	No			a					0	TaTh	i+0	
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15-0036 filed within 72 hours after I Hygiene. ed other than "natural", o t, the Medic I Examiner r	Completed	15. Oecedent's Edit				1-4 or 5+)	ea) 16a	during mo	st of worki	ng life. (TON OC	ise retired	d)	100.10	illa oi basii	100071110	.coay	
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-00; I with giene ther t	탕	17. Father's Name (, Last)				-		18	3.Mother's	Name (F	irst, Middle				_	
21215-0036 Uld be filed within 7 Mental Hygiene. marked other than c event, the Medic	Bec	John Da			ı Sr.						Lois	Jun	e Ham					
그 교육 등 하		19a. Informant's Nar	me/Relation:	ship (Type,	Print)		1	9b. Mailing	Address	(Street	and Numb	per or Ru	ral Route No	ımber, Cit	ty or Town,	State, 7	Zip Code)	
and 2 shou lealth and N tem 27 is n traumatic		I. Russel	ll Wil	bar /	′ Hus	band	7	71 Nep	otune	Dri	ve,	Jopp	a, Mar	ylar	nd 210)85_		
re, ML s 1 and 2 s of Health a If item 27		20a. Method of Disp	osition				20b. Place	e of Disposi atory or oth	ition (Name	of cem	etery,		Date	20c. L	ocation - C	ity or T	own, State	- 1
Baltimore, permit. Pages I au Department of He Important: If ite		1 Burial 2 Donation 5			Removair			op Se		e Cc	m. 1	10-19	2-07	TOW	son,	Mar	vland	a 1
Baltir permit. I Departme Importa injury or		Signature of Fur					111.11						e, P. <i>I</i>				1000	
iii iii iii iii iii iii iii iii iii ii		23a. Part I. Enter the	NIN	mas	Lev	with		113	17_Co	kesh	urv	Road	. Abii	nador	. Mar	cyla	nd 21	009
Physician		23a. Part I. Enter the	e disease, o	r complicat	ions that	caused the	death. Oo	not enter th	ne mode of	dying, s	uch as ca	rdiac or r	espiratory a	rrést, sho	ck, or hear	, _	Approxim Between	ate Interval Onset and
/Medical xaminer	9	Immediate Cause (F		C		unshot V	Vound o	f Head									D	eath
Kaillillei		or condition resulting	ig in death)	Oue	to (or as	a conseque	ence of):											
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3760, ficate b g physic s the bu	Physician/Medical	IF FEMALE: 23b. Was decedent :		the	23c. If yes	, outcome o birth	of pregnanc	cy ∘a∏ Fe	tal death	3	Ectopic	pregnan	су	230	d. Date of d Month	,	ay	Year
Box 68's death certiff	흥	past 12 months		4		nant at time			her (Speci					1				0
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n of Vital ling Physician: After this certi funeral director	Ë	27. Manner of Oeat			28a. Dat	e of Injury th, Day,Year) D:	281	b. Time of I	njury 2	8c. Injur	y at Work		28d. Describ Subject sh		ury occurre	d		
ion:	ţį	1 Natural 2 Accident		nding estigation	FOUN Oct 15			DUND: 500 hrs		1 Y	es 2 🗸	No	, abjoot o					
Division tal or Attendi rs after death.	ij	3 Suicide		uld not be	28e. Pla	ace of Injury	- At home	, farm, stre	et, factory,	office bu	uilding, et	c. 2	28f. Location or Town		and Numbe	r or Rur	al Route N	umber, City
Divi pital or ours afte teral Dir	Certification:	4 Homicide		ermined		v) under						- 1	1 Neptune	Drive ,				
		29a. Certifier (Check only	Certifying I Medical Ex	hysician:	To the be	est of my kr	nowledge, o	death occur	rred at the	time, da	te and pla	ice, and o	tue to the ca	use(s) ar	nd manner a	as state	d.	
To the Hos within 24 h To the Fur	ledical			an	d manner	s of examina stated.	ation and/c	or investiga				corred at	the time, de		Date signe	_		201
	Σ	29b. Signature and	title of certif	ier					290.		e number	OCME			ober 16,			di)
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ate of Maryland / Department of Health and Mental Hygierie	33413

Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death October **Physician** 2007 Carl Μ. Wehrmann Jr. 10:42 PM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 1553 Baywood Lane Pasadena Anne Arundel If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, May 29 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☑ M 2 ☐ F 185-32-6026 64 Yrs PA Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland to Health and Mental Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f ehow other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Maryland Directo Anne Arundel Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or Items 23a or 1553 Baywood Lane 21122 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: White þ If Yes, Give Year or Dates: Specify: 3 ☐ Widowed 4 ☐ Divorced "netural". Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) than College (1-4or 5+) permit. Pages 1 and 2 should be filled w
Department of Health and Mental Hygien
Important: If Itam 27 is marked other the Manager Printing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Carl Μ. Wehrmann Sr. Leona Bader 9 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Wehrmann (spouse) 1553 Baywood Lane, Pasadena, MD 21122 20b. Place of Disposition (Name of cemetery, crematory or other place) Oct. Date 18 2007 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) R.A. Ferris & Co. West Chester, PA 22. Name and Address of Facility 21. Signature of Funeral Service Ligensee Stallings Funeral Home, P.A. 3111 Mountain Road, Pasadena, MD 21122 ischi Approximate Intervat Between Onset and Death Part1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) **Physician** un4 Cancey /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Errier Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-transit attending physicien and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical for use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetat death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 Other (specify) the be deteched 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>م</u> 1. Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performe 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No To the Hospital or Attending Physician: funeral director. 25. Was case referred to medical Be 26. Place of Death | Check only one examiner' Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of within 24 hours after death. To the Funeral Director: After Injury 1 Natural 5 Pending 1 Tes 2 No 2 Accident investigation filled in by the 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number Will 022568 Co-30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5 Columbia Road Columbia, mo 21046 old 13 10000 mo 32 Registrar's Signature 31. Date filed (Month, Day, Year) State 2007 OCT 18 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Virginia Emma Yarbough 6:00 15 2007 October /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Saint Agnes Hospital Baltimore 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Month, Day 2-13-1925 Birthplace (State or Foreign Country) **Funeral** 1□ M 2 F Months Days Hours 217-18-2850 Director 82 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location a or 28a-f show t be notified at 10d. Inside City Limits Director 1X Yes 2 □ No M n/a Baltimore 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 912 Allendale Street permit. Pages 1 and 2 should be tiled within 72 hours after death wire Department of Heatth and Mental Hygiene. Important: If item 27 Is marked other than "natural", or Items 23a any Injury or other traumatic event, the Medical Examiner must b 21229 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 2 No if Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify specify: African-American þ 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 10th Damestic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Venus Yarbough Evergreen Richardson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Naomi Yarbough/ Daughter 912 Allendale Street, Baltimore, MD 21229 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) King Memorial Park 10-20-07 Woodlawn, MD 22. Name and Address of Facility Wylie Funeral Home P.A. of Balto. Co. 21. Signatur of unitral Service Licen 9200 Liberty Rd., Randallstown, MD 21133 Z3a. Part. Enter the disease or confederation of the confederation of th complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Metabolic Acidosis o hours /Medical Due to (or as a consequence of): Examiner Sepsis 10 hours Sequentially list conditions, if my leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Esia to for as a consequence of: Examine Abdominal Wound Infection 1 week Due to (or as a consequence of): Wound Dehisence 1 Wieks Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Month 4☐Pregnant at time of death Day Year 5 ☐ Other (specify) 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Congestive Heart failure, Hupertension. 1 ☐ Yes 2 No 3 Probably 4 Unknown Be Completed indings available ion of cause of Кo te Number

Yar bough, Virginia Division or Vital Records, P.O. Box 68760, Attending Physician;

Baltimore, Maryland 21215-0036

and attending physician for use as the buria as ed by the signed by certificate Hospital or

show

Certification: To

To the Hospital o within 24 hours aff To the Funeral Di completely filled in Medical

Renal Insuffi	ciency, color	n Cancer			24a. Was an autopsy performed?/ 1□ Yes 2 \ No	24b. Were autopsy fi prior to complet death? 1 \(\text{Yes} \) 2
25. Was case referred to medical examiner? 1 Yes 2 Vo	Hospital: 1 Inpatient 2	☐ER/Outpatient 3☐I	Othor	ace of Death (C	theck only one) 5 ☐ Residence 6	Other (Specify)
27. Manner of Death 1 Vatural 5		28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2		. Describe how injury	occurred Number or Rural Rou

29a, Certifier

1 Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year) October 15

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

900 Caton Avenue Baltimore, Maryland 21229 Gerard De Castro

31. Date filed (Month, Day, Year)

OCT 18 2007



(Resident)

State

Registrar

State of Maryland / Department of Health and Mental Hygien 2007 33475 1 - For State Registrar Certificate of Death Reg. No. 3. Time of Death Decedent's Name (First, Middle, Last) 2. Date of Death Villalta Arevalo Sept. 29 2007 ear 11:27p **Physician** Eduardo Exequiel /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death
Montgomery **Examiner** Silver Spring Holy Cross Hospital If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign Maryland 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 3 4 Months 12 M 2□F Director none Usuel Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or Items 23e or 28e-1 show maryiningy or other treumatic event, Ing M. ulcul Exa. ultist is at the mutilise of ADGE. 10c. City, Town or Location Silver Spring 10d. Inside City Limits 10a. State 10b. County Md Montgomery 1 ☐ Yes 2 No Director 10f. Zip Code 20903 10g. Citizen of What Country? 10e. Street and Number USA 427 Southampton Drive Funera 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married 18 Yes 2□No El Baltimore, Maryland 21215-0036 Salvador Specify: White ģ 3 Widowed 4 Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) none none 0 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Maria Blanca Arevalo Mario Villalta 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 427 Southampton Drive Silver Spring, Md20903 Mario Villalta/Father 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Permoval from State 10/04/2007 Silver Spring,Md Gate of Heaven * 4 □ Donation _5 □ Other (Specify 21. Signature of Pineral Service Li PHYTE ITPACTOS RINALDI FUNERAL SERVICE, P.A. 9241 Columbia Blvd.Silver Spring,Md20910 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Pulmonary typoplasia Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Polycystic kidney Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner Absent right kidney The faw requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Anahydranthios Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4□Pregnant at time of death 5 Other (specify) ed by the a 1 Yes 2 No 9 🗆 Unknown s been signed b should be deta 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has t autopsy performe 1 Yes 2 No 1 Yes 2X No or Attending Physiclen: director Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1

☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To After the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 XNatural 5 Pending 1 ☐ Yes 2 ☐ No within 24 ho is after death. To the Funeral Director: A completely filled in by the fu 2 Accident investigation 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 THomicide 12 Certifying Physician: To the best of my Knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated:
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifiei Medica (Check only onel 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifig D43696 ho completed cause of death (Item 23a) (Type, Print) 30. Name and address of person MD 1300 Forest Glen Rd. Silver Spring, Md 20910 Coates Tamara 31. Date filed (Mont) Registrar's Signature V 0'4 State 2007 Registrar

ary Adams		1- For State	laryland / Depar Certi	tment of		Mental Hy		20	07 33470
Physici edical Exami		1. Decedent's Name (First, Middle,Last) MARY ELLEN ADAMS					2. Date of Death	Dav Year	3. Time of Death 1903 hrs
		Facility Name (if not institution, give street Memorial Hospital	t and number)	4	b. City, Town, or L Cumberland			4c. County of D Allegany	eath
Funeral Director		5. Social Security Number 6. Sex 1 M 2	7. Age (In yrs. las	t birthday) Yrs.	If Under 1 Year Months Days	If Under 24Hrs. Hours Min.	8. Date of Birth 11/12/	E	Birthplace (State or or oreign Country) MARYLAND
nd how any ce.	<u>.</u>	Usual Residence of Decedent 10a. State 10b. County WV MINERAL		own or Location	ρΠ				10d. Inside City Limits 1 Yes 2 X No
the Maryland a or 28a-f show tified at once.	Director	10e. Street and Number BLOCKER STREET			10f. Zip Code 26753			g. Citizen of What	Country?
AD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Montale Higgiene. 27 is marked other than "matural", or items 23a or 28a-f shu antic event, the Medical Examiner must be notified at once	Funeral		Vas Decedent Ever in U.S. Irmed Forces? Yes 2 X No Give Year	If Ye		panic Origin? (Spe Mexican, Puerto F		. White, et	merican Indian, Black, c.
5-0036 led within 72 hours af Hygiene. I other than "natural the Medical Examin	pleted by	or Date 15. Decedent's Education (Specify only high	es:	6a. Decedent	s Usual Occupationstoners of working life. I	on (Give kind of wo		16b. Kind of Busine	
21215-0036 unld be filed within 7 Mental Hygiene. marked other than c event, the Medical	Be Comple	17. Father's Name (First, Middle, Last) RANDOLPH B. COSNER			1	8.Mother's Name (aiden Surname)	
e, MD 21 I and 2 should Health and Me item 27 Is ma	P.	19a. Informant's Name/Relationship (Type, Pr	PHER	ROUTE	4, BOX 1	159DD, RI	DGELEY,		53
는 s 년 드립		20a. Method of Disposition 1 X Burial 2 Cremation 3 Rer 4 Donation 5 Other Specify:	moval from State cre	TAWN N	EML.GARI	DENS 09/2	21/2007	20c. Location - Cit	
		21. Signature of Funeral Sérvice Livensee 23a. Part I. Enter de disease, or complication	hunch	1 2	02 GREEN		CUMBE	RLAND, M	
Physician Medical xaminer	0.7	failure. List only one cause on each line Immediate Cause (Final disease a. Multip			e mode or dying, s	such as cardiac of	respiratory arres	st, shock, or near	Approximate Interval Between Onset and Death
, W=	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated	(or as a consequence of):						
e be executed	edical E	d. UNPENDED X AME	NDED 28f per ur	eo g872 :	10-18-07 v	t			
(ecords, P.O. Box 68760 The law requires that the death certificate the law been signed by the attending physing 2 should be detached for use as the bu	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 ✓ Unknown g	If yes, outcome of pregnative birth Pregnant at time of deat Unknown	2 Feta	al death 3 er (Specify)	Ectopic pregnan	су	23d. Date of del Month	very Day Year
P.O.	by	Part II. Other significant conditions contrib		ulting in the ur	derlying cause giv	ven in Part I.			e to the cause of death? Probably 4 Unknown
2 8 8 7	Completed			_	-		24a. Was ar autops perform 1 Yes 2	y prior ned? deat	e autopsy findings available to completion of cause of h?
Vital F ysician: his certifi director,	o Be C	25. Was case referred to medical examiner? 1 Yes 2 No	1 ✓ Inpatient 2 E	R/Outpatient	[c	of Death (Check or Other 4 Nursing	·	Residence 6 C	Other:
ion of tending Pheath tor: After t		27. Manner of Death 28.	(Month Day Year)	8b. Time of In				ow injury occurred outo collision	
Division of Vital Rec To the Hospital or Attending Physician: The I within 24 hours after death To the Funeral Director: After this certificate I completely filled in by the funeral director, page	Certification:	3 Suicide 6 Could not be determined (5)	Be. Place of Injury - At home $Specify$ Major Road	/ Highway		R	or Town, Sta t. 28 South of	ate) Goldsboroh Roa	
To the Ho within 24 To the Fu	Medical	one) 2 ✓ Medical Examiner: On the			on, in my opinion,	death occurred at			
	M	29b. Signature and title of certifier	enti, miD.		29c. License O.C.M			29d. Date signed September 18	
10		30. Name and address of person who complete Donna M. Vincenti, MD Assis	tant Medical Exami	ner 111	Penn Street, I	Baltimore, MD	21201		
St Regist	tate trar	31. Date filed (Month, Day Year) 8 2007	32. Registrar's Signature	K Con	was -				
DHMH 17 Rev 1/2	001		0	ORIGINAL					

DHMH 17 Rev 1/2001 OCME 2006

07-07904 Alfred

Me

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

d H. Barger		- For State	State	of Marylar	nd / Depar	tment of ificate of	Health a	na ivienta	аі пудіє		20	07	3347
	<u>F</u>	Registrar 1. Decedent's Nam	o /First Middle La	et)	Cert	ilicate of	Dealli			Reg. ate of Death	NO.		of Death
Physicia al Examir			lfred Han		. r				O O	onth C ctober 10,	ay Year 2007	142	0 hrs
al Exami		4a. Facility Name (- 4	b. City, Town,	or Location of	Death		4c. County of De		
		1481 Wese	el Boulevard				Hagerstov				Washington		
Funeral		5. Social Security I	Number 6. S	Sex 7	'. Age (In yrs. Ia	st birthday)	If Under 1 Y	ear If Under	1.60		MM/DD/YYYY) 9. Fo	Birthplace (S	ry land
Director		220-16 - 2	734	M 2 F	81	Yrs		ays i riouis	J	uly 8,	1926	Country) G	ı y ranıd
	t	Usual Residence of			T.o. or							10d. In:	side City Limits
* any	ı	10a. State	10b. County		10c. City,	Town or Locati							Yes 2 X No
land f sho	ē	Md.	Frede	erick		Smiths	Durg 10f. Zip Code	9		100	. Citizen of What C	Country?	
Mary r 28a-	Director	10e. Street and Nu	umber Wolfsvi	llo Pd				1783		109	U.S		
fter death with the Maryland 1", or items 23a or 28a-f show ter must be notified at once.			WOTISVI		edent Ever in U.S	s 13 Wa	as Decedent of		in? (Specify	Yes or No-	14. Race - Ar		an, Black,
ath wi tens	Funeral	 Marital Status Never Marr 	ried 2 Marrie	Armed For		If Y	es, specify Cut	ban, Mexican,	Puerto Rica	n, etc.)	White, et	c.	
ter des		3 X Widowed	4 Divorce	1 X Yes ed If Yes, Give Year	44 46	1	Yes 2 X	No specify:			Specify:	White	
urs af turaf amin	d by		ducation (Specify	only highest grade	e completed)	16a. Deceder	nt's Usual Occu	ipation (Give k	kind of work	done	16b. Kind of Busine	ess/Industry	
72 ho n "na al Ex	lete	Elementary/Sec	condary (0-12)	College (1-	4 or 5+)		chine O			ł	Railro	ad	
vithin ene.	Completed	7								st Middle Ma	aiden Surname)		
Hygi d oth	e Co	17. Father's Name		st)				TO.IVIOLITES			yboued		
112 Id be Jental narke	B		Barger Name/Relationship	(Type, Print)		19b. Mailin	g Address (S	treet and Num	ber or Rural	Route Numb	er, City or Town, S	state, Zip Co	ode)
S shou and N and N and I matic	To		A. Barge							wick,	ld. 2171 <u>6</u>		
and 2		20a. Method of Di	isposition			Place of Dispos crematory or of	sition (Name of	cemetery,	Oct.	ate	20c. Location - Cit	y or Town, S	State
DOC ages l nt of l other		1 X Burial 2	Cremation 5 Other Spec	Removal fro		.Bethel		ery	2007		Foxvill	e,Md.	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once		21. Signature of F	uneral Service Lic	ensee			Name and Add		у	12	2525 Brad		
Ba Dep Ting		I Per	Le I	Juis							nithsburg		21783 roximate Interval
Physician		23a-Part I. Enter failure. List o	the disease, or co	mplications that ca each line.	aused the death	. Do not enter	the mode of dy	ing, such as c	ardiac or res	spiratory arre	st, snock, or neart	Betv	ween Onset and Death
Medical xaminer		Immediate Cause	e (Final disease	a. Head Injurie								-	Death
		or condition resu	iting in death)	Due to (or as a	consequence o	rt):							
	er	Sequentially list of if any, leading to	immediate	Due to (or as a	consequence o	of):							
-	Examine	cause. Enter Un (Disease or injury	y that initiated	C. Due to for se s	consequence of	nf):							
P. be _ tis	Exa	events resulting i	in death) Last	d.	consequence	,,,,							
50, te be executed ysician and burial - transit	ledical	UNPENDE	D	AMENDED									
60, ate be hysici e buri	Med	IF FEMALE:		23c. If yes,	outcome of preg	gnancy					23d. Date of de	•	
687 ertifica ding p	au/	23b. Was decede past 12 mont	nt pregnant in the ths?	1 Live b	oirth nant at time of de		etal death		ic pregnancy	/	Month	Day	Year
Sox 6876 leath certificate e attending phy for use as the	Physician/N	1 Yes 2	No 9 Unkno			eath 5 C	Other (Specify)						
O. B. trithe de by the	俻		nificant condition	ns contributing to	o death but not i	resulting in the	underlying car	use given in P	Part I.		bacco use contribu		
P.C es that igned be det	à									1 Yes	2 V No 3		
'ds, requir been s	Completed									24a. Was autop	sy pri	or to comple	findings available tion of cause of
e law e has l	ם									perfor		ath? ✔ Yes	2 No
Rectification, pag	ပိ	25. Was case re	ferred to medical	1			26.1	Place of Death	(Check onl	y one)			
Vital Records, P.(hysician: The law requires that this certificate has been signed al director, page 2 should be det	o Be		2 No	Hospital: 1	Inpatient 2	ER/Outpatie	nt 3 DOA	Other ₄	Nursing H	Home 5	Residence 6	Other: Scen	ne
1 of V ling Phy After th	-	27. Manner of De		28a. Date	of Injury	28b. Time o	f Injury 28c	. Injury at Wor	Di		now injury occurred fixed object co		
On tendin eath. or: A	atio	1 Natural 2 Accident	5 Pendir Investi	astion	2007 (2007)	1408 hrs	1	Yes 2 ✓	No		_		
ViSi or Att filter d Direct in by] :::	3 Suicide	6 Could	not be 28e. Plac	ce of Injury - At I	home, farm, str	reet, factory, of	fice building, e			Street and Number State) Boulevard, Hage		
Di spitat ours a nerat I	Certification:	4 Homicid		(-13)	Major Roa								
Division of Vital Records, P.O. Box 68760, To the Hospitat or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi			Certifying Phy Medical Exam	sician: To the be iner:On the basis	st of my knowle of examination	dge, death occ and/or investig	curred at the ting gation, in my or	ne, date and p pinion, death c	place, and du occurred at ti	ie to the caus he time, date	se(s) and manner a and place, and du	e to the caus	se(s)
To th withii To th	Medical	2 (and title of certifier	and manner	stated.			icense numbe			29d. Date signed		
	2		ma mo	mart.				D.C.M.E.			October 11,	2007	
			ddress of person v			m 23a)							
7			. Vincenti, MD		Medical Exa		11 Penn St	reet, Baltin	nore, MD	21201			
\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	State			32. R	Registrar's Sign		A						
Regi			JCT 1 8 2	007 July	eur D	ture							

ORIGINAL

OCME

Division or Vital Records, P.O. Box 68760 within 24 hours after death To the Funeral Director:

> 5 State Registrar

31. Date filed (Month, Day, Year)

29b. Signature and title

GUPTA, M.D. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

10033280

29d. Date signed (Month, Day, Year)

GAS KENT AVE CUMBERLAND, MD 21503

			1 - For State Registrar		State o	of Maryl	and / De	partme <i>ertifica</i>					giene Reg. No		33479	3
	Physici		1. Decedent's Name (F			hries	5	Brow	n		2	Date of De Month OCT.	ath		3. Time of Death 10:30p N	A
	/Medic Examir		4a. Facility Name (If no.	-					y, Town, o					County of Death		
	Funeral Director	7/59	5. Social Security Numb 223-30-08	329 1	ex □M 2□F	7. Age (In) 8 C	yrs. last birthd Yrs	Month	der 1 Year s Days	If Under Hours	Min.	Date of Bir (Month, Da 2/17	th ay, Year) 1192	9. Birti Co Vir	nplace (State or Foreig untry) ginia	n
-	f ehow	ō		cedent b. County [ontgo:	nery		. City, Town or Gaithe		rg						10d. Inside City Limits	
	ith with the Maryla 23s or 28s-f ehoves	Funeral Director	10e. Street and Numbe 108 East		Park D	rive			Zip Code 0877				_	zen of What Co	untry?	
36	er de (iteme	by Funera	11. Marital Status 1 Never Married 3 Widowed 4		12. Was Dec Armed Fo 1 Tyes If Yes, Gi Year or D	orces? 2 □ No 1 ve 1	in U.S. 1 944- 952		cedent of H pecify Cuba 2 🙀 No	ispanic Or an, Mexica Specify		rfy Yes or No can, etc.)		14. Race - Ame Black, White Specify: W		
Marviand 21215-0036	within 72 hound. ne. hen "neture Medical E	Be Completed by	_ 15	. Decedent's Econly highest gra	ducation		16a. De	ecedent's U live kind of e. DO NOT Wel	work done o use retired	ation during mos	st of working	7		nd of Business/		
land 2	ild be filed v fental Hygie rked other t ilc event, in	To Be Co	17. Father's Name (First John Hen					MET	uei			First, Middle	, Maiden	Sumame)	Gas	
Baltimore. Marv			19a. Informant's Name Ruth Brow 20a. Method of Disposi 1♥ Burial 2 □ C 4 □ Donation 5 □	n/Wife	Removal from	-	1 0 b. Place of Di	8 Ea	st De	eer	Park Dan	Dr.	Gait	cation - City or	rg,Md208	7
	permit. Departmine importa eny inju		21. Signature of Funera	Den	whon	·		9241	Col	umbi	a Blv	d.Si	lver	SERVIC Sprin	CE, P.A.	Û
SEK INE	Physician /Medical	ķ,	23a. Part1. Enter the dishock, or heart fall immediate Cause (Findisease or condition resulting in death)		a. Ca	rdiac	Arre		ode of dyin	g, such as	s cardiac or i	respiratory a	rrest,		Approximate Interval Between Onset and Death	_
OK AS 1'S 7 8760.	cate be executed by physician and the burial-transit	dical Examiner	Sequentially list condit if any, leading to infine cause. Enter Underlyin Cause (Disease or inju that initiated events resulting in death) Last	ions, cliate ng ry	b. Re	spira Grasa son ronic	tory C Lung sequence of): cerial	Dis	ease							
າ < 0. Box 6	w requires that the death certific been signed by the attending p should be detached for use as	Completed by Physician/Me	IF FEMALE: 23b. Was decedent prein the past 12 moint past 12 moint past 12 moint past 12 moint past 12	nths?		birth 2 □ F nant at time	Fetal death	3 □Ectopic 5 □ Other					2	3d. Date of deli Month	very Day Year	
rds. P.	quires that en signed by ould be deta	ed by Ph	Part II. Other significan				resulting in th	e underlyin	g cause giv	en in Part	l.				the cause of death?	n
al Reco	: The law recate has be page 2 sho	Complet										24a. Was auto perfo 1 Yes		death?	topsy findings available completion of cause of	В
Division of Vital Record	Attending Physician: The law requires that the death certific refers. After this certificate has been signed by the attending by the funeral director, page 2 should be detached for use as	Certification: To Be	2 Accident	i ☐ Pending investigation	28a. Date (Mon	of Injury oth, Day Yea		e of ry M	28c. Injur Wor 1 🗆	er: 4□N	ursing Home 28	d. Describe	dence 6 how injury		cify) rai Route Number,	
Div	To the Hospital or Attendi within 24 hours after death To the Funeral Director: A completely filled in by the fi		4 ☐ Homicide 29a. Certifier 1₺	determined Certifying Ph	build sysician: To the	ing, etc. (Sp	knowledge, de	eath occurr	ed at the tin	ne, date a	nd place, an	City or To	wn, State)	and manner as	stated.	
	To the To the Comp	Medicai	(Check only 2 200) 29b. Signature and title		niner: On the B and man	pasis of examiner stated.	nination and/o		29c. Licens			at the time,	29d. Date	place, and due	n, Day, Year)	
	10		30. Name and address Hamid Ma		completed cau						•	e Roc		11e.Md	07 20850	
	Sta Registr		31. Date filed (Month, L		32.4	egistrar's S	ignature	haele								

			. 101	partment of Health and Mertificate of Death	lental Hygien	2007	33480
8	Physici		1. Decedent's Name (First, Middle, Last) Marian Elizabeth Brawner		2. Date of Death Sept. 25 ^D	^{ay} 2007 ^{ear}	3. Time of Death 1412 м
意	/Medic Examir		4a. Facility Name (If not institution, give street and number) Washington Adventist Hospital	4b. City, Town, or Location of Death Takoma Park		c. County of Death Montgome	ry
2 2 3 4 4	Funeral Director	- 1	5. Social Security Number 6. Sex 1 M 2 Q F 7. Age (In yrs. last birthda) 86 Yrs.	// If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Yea 1/15/19	9. Birthpi Coun Mass	ace (State or Foreign try) achusetts
	Maryland 8-f ehow flied at	tor	Usual Residence of Decedent 10a. State MD Prince George's Hyatts			10	0d. Inside City Limits 1 ☐ Yes
	with the	Direc	10e. Street and Number 6305 Riggs Road #105	10f. Zip Code 20783		citizen of What Coun	try?
036	within 72 hours atter death with the Maryland ene. then "natural", or Items 23e or 28e-f ehow fre Mccleal Evernirer must be mulfied at	by Funeral Director		Was Decedent of Hispanic Origin? (Sprif Yes, specify Cuban, Mexican, Puerto		14. Race - Americ Black, White,	
21215-0036	within 72 ho ene. then "natur ne Modical	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	edent's Usual Occupation re kind of work done during most of work DO NOT use retired) motologist	ing	Kind of Business/Ind	·
Maryland 2	uid be filed Mental Hygie Inked other Itlc event, III	To Be Co	12 17. Father's Name (First, Middle, Last) unknown	18. Mother's Name	n Butter	en Surname)	
Baltimore, Mary	permit. Pages 1 and 2 should be filed within 72 hours atter death with the Marylan Department of Health and Mental Hyglene. Important: If item 27 is marked other then "natural", or items 23s or 28s-f show may intry or other traumatic event, the Medical Examinar must be nutified at once.		Julie J.Sarwatt/Friend 942 20a. Method of Disposition 1 Burial 2 DiCremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of uneral Serventic Insections	peake Crem 10/02 PAILIP D.RINALDI	#2 Hyatt: 20c. /2007 B6 FUNERAL	sville,M Location - City or To eltsvill SERVICE	d 20783 wn, State e, Md
8760,	Physician be executed by physician and by sician and physician and sthe burial-transit	dical Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last C. Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	nier the mode of dying, such as cardiac of the mode of dying, such as cardiac of the mode of dying, such as cardiac of the mode of dying, such as cardiac of the mode of dying, such as cardiac of the mode of dying, such as cardiac of the mode of dying, such as cardiac of the mode of dying, such as cardiac of the mode of dying, such as cardiac of the mode of dying, such as cardiac of the mode of dying, such as cardiac of the mode of dying, such as cardiac of the mode of dying, such as cardiac of the mode of dying, such as cardiac of the mode of the mode of dying, such as cardiac of the mode of the mode of dying, such as cardiac of the mode of the m			Approximate Interval Between Onset and Death
.O. Box 6	death certit e attending ad for use as	Physician/Medical		□ □Ectopic pregnancy □ □ Other (specify)		23d. Date of delive Month	ory Day Year
Ω.	law requires that the as been signed by th 2 should be detache	þ	Part II. Dther eignificant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacco	use contribute to the	ne cause of death? ably 4 Nunknown
Vital Records,	The law recate has been page 2 sho	Completed	- dung Cumcer		24a. Was an autopsy performed?	prior to cor death?	psy findings available inpletion of cause of
of	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: Atter this certificate his completely lilled in by the tuneral director, page	ition: To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No 1 ☐ Inpatient 2 ☐ ER/Outpati 27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident (nvestigation) 28a. Date of Injury (Month, Day Year) (Month, Day Year)	ent 3 DOA Other: 4 Nursing Ho of 28c Injury at	th (Check only one) ome 5 Residence 28d. Describe how in		y)
Division	tal or Attandi rs after death. al Director: A ed in by the tu	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, so building, etc. (Specify)	street, factory, office	28f. Location (Street City or Town, Sta		l Route Number,
	he Hospital in 24 hours a he Funeral E pletely tilled	edicai	29a. Certifier (Check only one) 1 Certifying Physicien: To the best of my knowledge, de 2 Medical Exeminer: On the basis of examination and/or and manner stated.				
)	To the within 2 To the Complet	M	29b. Signature and title of certifier	29c. License number	7 29d. [Date signed (Month,	Day, Year)
	Sta Regist		31. Date tiled (Month, Day, Year) 32. Higgistrar's Signature	e, Print) 211 Avenue Takom	a Park,Mo	20901	

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Day Year Edgar F. Behrens <u>10:</u>00∰ 2, October 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Renaissance Gardens/Riderwood Silver Spring Prince George's 8. Date of Birth (Month, Day, If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Social Security Number 6. Sex 7. Age (In yrs. last birthday, 9. Birthplace (State or Foreign **Funeral** Days Year) 85 Director 390-16-9445 18,1921 Wisconsin Oct. Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a, State ral", or items 23a or 28a-f show Examiner must be notified at 10d. Inside City Limits Director Maryland Prince George's Silver Spring 1 ☐ Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3142 Gracefield Rd., MG219 20904 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 DYes 2 No WWII
If Yes, Give
Year or Dates: Korea 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2 ☐ XNo Specify: White ģ Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) I.R.S. <u>Computer System Analyst</u> permit. Pages 1 and 2 should be flied of Department of Health and Mental Hygis Important: If item 27 is marked other any injury or other traumatic event, the 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Gertrude Koehn George E. Behrens ပ 19a. Informant's Name/Relationship (Type. Print)
Ruby M. Behrens/Wife 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) $20904\,$ 3142 Gracefield Rd., MG219, Silver Spring, 20b. Place of Disposition (Name of cemetery, crematory or other place)
Metropolitan 20a. Method of Disposition 20c. Location - City or Town, State 2, 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Oct. 4 ☐ Donation 5 ☐ Other (Specify) 2007 rematory Alexandria, Virginia 21. Signature of Funeral Service Licensee Francis J. Collins Funeral Home Inc. 500 University Blvd, W, Silver Spring, MD Approximate 0 0 0 Interval Between Onset and Death 10 yrs. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Parkinson's Disease /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 attending physician Physician/Medical IF FEMALE If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 1∐ Yes 2X No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 ☑ No 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of After t 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29d. Date signed (Month, Day, Year) October 2, 2007 29b. Signature and title D24093 all 10+1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Mark Parkhurst, M.D 3110 Gracefield Rd., Silver Spring, MD 20904 31. Date filed /M 32. Bgistrar's Signature State 2007 Registrar

DHMH 17 Rev 1/2001

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturar" or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 3 Baltimore, Maryland 21215-0036

Physician

Examiner

Funeral

Director

/Medical

10a. State

Director

Funeral

Completed by

Be

၉

19a. Informant's Name/Relationship (Type. Print)

4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License

20a. Method of Disposition

Immediate Cause (Final

disease or condition resulting in death)

Donald.

Stuart E. Bannett - Son

1 X Burial 2 ☐ Cremation 3 ☐ Removal from State

Physician /Medical Examiner

law requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760,

ner	Sequentially list conditions, if any, leading to immediate cause. Enter underlying	b. Due to (or as a consequence of):		
ical Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c		
ilysiciaii/ineulcai	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pri 4 ☐ Pregnant at time of death 5 ☐ Other (spingle) ☐ Other (spingle)		23d. Date of delivery Month Day
2	Part II. Other significant conditions	contributing to death but not resulting in the underlying ca	ause given in Part I.	23e. Did tobacco use contribute to the cause 1 Yes 2 No 3 Probably 4
nandiii.				24a. Was an 24b. Were autopsy findir autopsy performed? death? 1 □ Yes 2√□ No 1 □ Yes 2√□ No
ľ	25. Was case referred to medical		26. Place of Death (1 11
	examiner? 1 ☐ Yes 2X No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DO	O4h	5 Residence 6 □Other (Specify)
	27. Manner of Death 1 X Natural 5 ☐ Pending 2 ☐ Accident investigation			d. Describe how injury occurred
	3 ☐ Suicide 6 ☐ Could not to determined		, office 28f	Location (Street and Number or Rural Route N City or Town, State)
	29a. Certifier (Check only one) 1 Certifying P 2 Medical Exa	hysician: To the best of my knowledge, death occurred iminer: On the basis of examination and/or investigation, and manner stated.	at the time, date and place, and, in my opinion, death occurred	d due to the cause(s) and manner as stated. at the time, date and place, and due to the cau
İ	29b. Signature and title of certifier		. License number	29d. Date signed (Month, Day, Yea
1	> pury voi		064115	OCTOBER 2, 2007

22. Name and Address of Facility
DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC. 1170 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 20852 Approximate Interval Between Onset and Death ath. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Deborah Dubin

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
P O. Box 88, Mt. Airy, Maryland 21/71

10/7/2007

Date

23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. Metastatic Lung Cancer Due to (or as a consequence of):

20b. Place of Disposition (Name of cemetery, crematory or other place)

Judean Mem. Gardens

Due to (or as a consequence of):

20c. Location - City or Town, State

Olney, Maryland

Year

use contribute to the cause of death? 2 No 3 Probably 4X Unknown

24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2▼I No 2**X** No

nd Number or Rural Route Number,

WOODS MERCER, 20850 9707 MEDICAL CENTER DRIVE, SUITE 300, ROCKVILLE, MD

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year) OCT 04 2007



State of Maryland / Department of Health and Mental Hygiene 33483 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** 8:15 ам Robert Anthony Ball 2007 October /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery Ashbury Methodist Village Gaithersburg 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Days 1⊠M 2□F Months Hours Min District of Columbia March 3, 1929 Director 78 578-40-2841 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c City. Town or Location 10a State 10h. County iral", or Items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 No Director Maryland Prince George's Laure 1 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 7328 Summerwinds Circle 20707 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: 1951-1956 14 Bace - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2 ☒ No Specify: Specify. ģ White 3 X Widowed 4 □ Divorced Completed Injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Publication Printer permit. Pages 1 and 2 should be file.
Department of Health and Mental Hy Important: If item 27 Is marked othe any Injury or other the state of the s 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mary Schilling Frank Ball 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5 Selby Court, Poolesville, Maryland 20837 Deborah Ray - Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Resurrection Cemetery 10/05/2007 Clinton, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Hines-Rinaldi Funeral Home, Inc. 21. Signature of Funeral Service Licensee 11800 New Hampshire Avenue, Silver Spring, Maryland 20904 23 Part1. Ent. r the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or leart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Kes One year **Physician** /Medical r as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner physician and sthe burial-trans Division or Vital Records, P.O. Box 68760, Physician/Medical use as IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Vear 5 ☐ Other (specify) 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by should be 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No es 2 🗹 No 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 2 ER/Outpatient 3 DOA မှ 1 🔲 Inpatient 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manyer of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1 Natural (Month, Day Year) Injury To the Hospital or Attendir within 24 hours after death.

To the Funeral Director: Air completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) OIRUSSELL 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KTBIRSCHBRELLAND 31. Date filed (Month, Day, Year) **∭**gistrar's Signature State OCT 04 2007 Registrar

		1	For State Registrar	State of N	Marylar		artmen e <i>rtificat</i>			and Mo		giene Reg. No.	007	33484	
	Physicia /Medic Examin	an al	Decedent's Name (First, Middle, Ham As Facility Name (If not institution,	BAILE	7	TR	4b. City,	Town, or	Location o	of Death	2. Date of De. Month Seys	L Day	Year 7 200 County of Death	3. Time of Death 3. O M	_
	Funeral Director		214-46-0237	6. Sex 113 M 20 F	Age (In yrs.	last birthda Yrs.	y) If Under Months	1 Year Days	If Under Hours	PC 24 Hrs. Min.	8. Date of Birl (Month, Da 09/09/	1946	('0	nplace (State or Foreign untry) tucky	
	ne Maryland 8e-f show	ector	Usual Residence of Decedent 10a. State 10b. County Maryland Anne A	rundel		ty, Town or	ville	0-4-				10a Citiz	en of What Co	10d. Inside City Limits 1 ☐ Yes 2 ☑ No	
	th with the 23a or 2	al Dire	10e. Street and Number 1308 Double Gat	e Court			2103	35				Unite	ed Stat	es	
036	be filed within 72 hours after death with the Maryland tal Hyglene. id other than "naturel", or items 23a or 28e-f show of other than "naturel", or items 23a or 28e-f show event, the Medical Examiner rust be notified a	by Funeral Director	11. Marital Status 1 Never Married 2 Marrie 3 Widowed 4 Divorced	12. Was Deceder Agned Force ed 1 1 Yes 2 [If Yes, Give Year or Date:	s? ∃No 19	979- 987	B. Was Deceing Yes, special Yes		spanic Ori n, Mexican Specify:		cify Yes or No Rican, etc.)	[4. Race - Ame Black, White Specify: Wh		
21215-0036	l within 72 ho iene. r than "natur ine Medical	Completed	15. Decedent (Specify only highes Elementary/Secondary (0-12)	's Education t grade completed) College (1-4c)	or 5+)	(Gir	cedent's Usua ve kind of wo . DO NOT u	al Occupa rk done d se retired)	ition <i>Juring m</i> os	t of workin	ng		d of Business/ structi		
Maryland 2	should be filed and Mental Hygis marked other martic event, III	To Be C	17. Father's Name (First, Middle, I William Bailey,	Sr.		10h Ma	ilia - Addraga		Mary	Loui	(First, Middle, Se Moo	re	Sumame) Town, State, 2	Zin Code)	
	t and 2 s teath ar om 27 is ther trau		19a. Informant's Name/Relationsh Paula Keenan/Fi 20a. Method of Disposition 1 □ Burial 2 ☒ Cremation	ancee	to at	1308 Place of Dis	B Doub	Le Ga ne of other place	ate C	ourt	, David	SONV	ille, Mation - City or	aryland 2103 Town, State	35
Baltimore,	permit. Pages 'Department of h Importent: If Ite any injury or of once.		4 ☐ Donation 5 ☐ Other (St. 21. Signature 1)	pecify)	Ka			nd Addres	s of Facili	⊎Geoi	rge P.	Kalas	s Funer	Maryland al Home,P.A D 21037	-
68760,	Cate be executed hypercian and hypercian and hypercian and the burial-transit	dical Examiner	23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or b. Due to (or c	as a conse	quence of):	2487	t C	14e	CATT	+ D		nse	Approximate Interval Between Onset and Death	
O. Box 6	at the death certificat by the attending phy tached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnan 9 ☐ Unknown	n 2 □ Fe tat time of	tal death	3 ⊟Ectopic p 5 ⊟ Other (s _i					2	3d. Date of de Month	livery Day Year	
rds, P.	law requires that the as been signed by th 2 should be detache	þ	Part II. Other significant condition	ins contributing to deat	h but not re	sulting in the	underlying	cause give	en in Part i	l. 		tobacco us		o the cause of death?	
al Record	The ate h page	Completed	25. Was case referred to medical						as Plan	o of Daath	24a. Was auto perfo 1 Yes	psy ormed? 2 2 4 p	24b. Were at prior to death?	utopsy findings available completion of cause of 2 No	
ion of Vital	ng Phys ter this neral di	atlon; To Be	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pendin 2 Accident investig	Hospital: 1 Inp 28a. Date of I (Month,	-	28b. Time Injur	e of	28c. Injury Work	er: 4□N	ursing Ho		idence 6	i ⊡Other (Spe r occurred	ocify)	
Division	7 4 7 6	Certification;	3 ☐ Suicide 6 ☐ Could i 4 ☐ Homicide determ	ined 200. Place of	Injury - At , etc. <i>(Spe</i> c		street, factor	y, office				(Street and wn, State)		ural Route Number,	
	To the Hospitel of within 24 hours af To the Funeral D completely filled in	Medical	29a. Certifier 1 Certifyin (Check only one) 1 Medical	ng Physician: To the be Examiner: On the basi and manner	s of exami	nowledge, de nation and/or	eath occurred r investigation	at the time n, in my of	ne, date ar pinion, dea	nd place, ath occurr	and due to the ed at the time	date and	place, and du	e to the cause(s)	
)	Som Som	Š	29b. Signature and title of certifie	- Roy	10	m		c. License		60	54		a signed (Mon		
_	LON LON		30. Name and address of person	P. 501	UCS	mg	De, Print)	69	56	Tme	eric	A	20	035	ij,
	Sta Regist	ate rar	31. Date filed (Month, Day, Year)	2 2007	jistrar's Sig	nature	bore								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Month Physician Mildred Tyler Bean 0 01-/Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Carroll Hospital Center Westminster Carroll If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days 1 □ M 2 🗙 F 217-10-8310 89 Director May 18, 1918 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at 1 Yes 2 No Funeral Director Carroll Westminster 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a or 1234 Washington Road permit. Pages 1 and 2 should be filed within 72 hours after death w Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a any Injury or other traumatic event, the Medical Examiner must bonce. 21157 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14 Bace - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No þ Specify: white 3 ☐ Vidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) homemaker 11 own home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Allen Tyler Frances Buckley 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Arden T. Bothe Box 2928, Winchester, VA daughter 22604 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Dorchester Mem. Park 10/4/07 4 □ Donation 5 □ Other (Specify) Cambridge, MD 21. Signatu 🍂 of Funeral Service Licensee 22. Name and Address of Facility Thomas Funeral Home P.A. 700 Locust St., Cambridge, MD 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) UROSEPSIS Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. attending physician Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 2 No 1 Tes 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Hospital or Attending Physician: The law requires that the death certificate be executed ours after death. within 24 hours a To the Funeral I

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

D30263

10-01-07

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

200 MEMORIAL AVENUE, WESTMINSTER MD FRANCIS KHOO MD

State Registrar

Medical

31. Date filed (Month, Day, Year) OCT 0.3 200

32. Reastrar's Signature

			1 - For State Registrar	State of M	M29d r arylan		c872 artmen rtificat			ind Me		giene Reg. No.!	Z 11 11 /	33	486
	Physici	an	Decedent's Name (First, Middle, Las	t)						1	Date of Dea Month	ath Day			of Death
	/Medic		Harold Ross	Berry			4 07				Oct.	4	2007	6:30	0 P M
1	Examir	er	4a. Facility Name (If not institution, give				1		Location o	Death			County of Death rrett	1	
	Funeral		Garrett County 5. Social Security Number 6. Se			last birthday)	If Under	klar 1 Year	If Under 2		B. Date of Birt	h	9. Birth	place (State	e or Foreign
	Funeral Director		233-34-4007	M 2□ F	81	Yrs.	Months	Days	Hours	Min.	(Month, Da)	192	6 W	intry)	
	P .		Usual Residence of Decedent		10- 01									10d. Inside	City Limits
	show	5	10a. State 10b. County			y, Town or Lo	cation								es 2 No
	the M	ecto	WV Tucker 10e. Street and Number		11	homas	10f. Zip	Code				10a Citi	zen of What Cou	/\.	
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	Jeath Tre 23	Funeral Director	2nd & Grant S	12. Was Decedent		.S. 13.			spanic Orig	jin? (Spec	ify Yes or No- ican, etc.)		14. Race - Amer		
9	or ite	Ē	1 Never Married 2 Married	Armed Forces' 177 Yes 2 ☐ If Yes, Give		- 1	ir Yes, spe 1 ☐ Yes			, Риело н	ican, etc.)		Specity: Wh		
93	Pari,	d by	3 Widowed 4 □ Divorced	Year or Dates:			10 100	212940	эрвспу.			-			
21215-0036	within 72 hours after death with the Maryland ane. then "natural, or iteme 23a or 28a-f show he Medical Examinar must be notified at	Completed	15. Decedent's Ed (Specify only highest grad			16a. Dece	dent's Usu: kind of wo DO NOT u	rk doné d	luring most	of working	7	16b. Ki	nd of Business/l	ndustry	
12	withir Bne. then	E D	Elementary/Secondary (0-12)	College (1-4or	5+)	Pipe		,	,			Co1	umbia	Gas	
0	e filed of Hygie other vent, II	Be Co	17. Father's Name (First, Middle, Last)			1 1			18. Mothe	r's Name (First, Middle,				
lan	lid be fenta rked	To B	Leonard Natha	n Berry					Doni	.se (Opal (Curr	y		
Maryland	s 1 and 2 should be filed within 72 hours after death with the Manjian if Health and Mental Hygiene. Item 27 is marked other then "natural, or items 23a or 28a-f show other treumatic event, the Medical Examinar must be multiled at		19a. Informant's Name/Relationship (7	Type, Print)		19b. Maili	ng Address	(Street a	in <i>d Numb</i> e	r or Rural	Route Numbe	r, City o	Town, State, Z.	ip Code)	
Σ.	ealth m 27		Cathy Phillips	/daughte		_	. Bo		33 T		as, WV				
Baitimore,	ges 1 t of H It ite		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □	Removal from State	, c	Place of Dispo emetery, crei	matory or c	ther place		Da			cation - City or 1		
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	Physician /Medical		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	one cause on each	line.									Approxim Interval B Onset an	Between
8760, 2	death certificate be executed by the settlending physicien end in dor use as the burial-transit in the settlending burial-transit in the settl	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as Due to (or as d.	mic s a consequence bnic s a consequence	945 uence of): - 005 uence of):	to-li Frue	car	ides : pe	hon elm	ic di owar	nsh y d	rlic her islase	ye.	ars
P.O. Box 6	thet the death certifica ed by the ettending pl detached for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Feta	Ideath 3	□Ectopic pi □ Other (sp					-	23d. Date of deli	very Day	Year
	res thet signed b	by P	Part II. Other significant conditions of	ontributing to death I	Ω		1	ause give	en in Part I.		1		se contribute to		
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Division	al or Attending s after death. I Director: After d in by the fune	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of In	ijury - Al ho ilc. (Specif		reet, factor	y, office		28	3f. Location (S City or Tox		d Number or Ru)	ral Route No	umber,
	To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer	edicai		ysician: To the best niner: On the basis of and manner s	of examina										e(s)
	To the within 2 To the complet	X	29b. Signature and title of certifier	. 1/	*		29	c. License	number	-		29d. Dat	e signed (Month	, Day, Year,)
)			Murgaret	agra	un 1	w		20	160	20		10/4/	07		
	10		30. Name and address of person who	completed cause of	death (Item	123a) (Type,	Print)	124	Land		2.1	0	d.ud	216	50
	\ 		31. Date filed (Month, Day, Year)	30/Rariet	rar's Signa	ture *	ga	reu	ruge	way	cun	rau	a · uu	017	10
	Sta Registr		OCT 1 8 20	N7 Maria	لكر م	LON	EREL								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 7 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Day AMES EDWARD 732 AM LARK 2007 SEPT 26 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** HOWARD COUNTY 8. Date of Birth (Month, Day, Year) 26,1947 GENERAL HUSPITAL LUMBIA HOWARD () Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Months Days **№** M 2 F Hours Director 227-66-9993 Maryland 60 Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10d. inside City Limits show r 28a-f show notified at 1. Yes 2 No Director MD Howard Columbia 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? pe o 5418 Eliott Oaks Road, #3 21044 U.S.A. 'natural'', or Items 23a dical Examiner must t Pages 1 and 2 should be filed within 72 hours after death vent of Health and Mental Hygiene. snt: If Item 27 Is marked other than "natural", or Items 23sury or other traumatic event, the Medical Examiner must Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: þ Specify: Black 3 ☐ Widowed 4X Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Construction 10th Carpenter 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Leon Clark ည Estelle Beck 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Cheryl Green Brooks (Cousin) 5427 Hildebrand Court, Columbia. Mi 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of Important: If I any Injury or I once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Riv**er**dale Pk Cre 10-1-07 Riverdale, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility SNOWDEN FUNERAL ROME, P.A. 21. Signature Funeral Service Liceus 246 N. Washington St, Rockville, MD 20850 e, or complications that caused the death. To not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. 23a. Part1. Enter the disea shock, or heart failure. Approximate Interval Between Onset and Death immediate Cause (Final **Physician** HUPERKALEMIA 1 DAD disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner REUNL FAILURE 20193 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner The law requires that the death certificate be executed 2 DAYS VOLUME DEPLETION burial-tra Due to (or as a consequence of): resulting in death) Last physician Physician/Medical DRRHEA the use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d Date of delivery in the past 12 months? 1 ☐ Yes 2 ☐ No 3 Ectopic pregnancy Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) ed by the detached 9□ Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? **p** CARDIUMYOPATH 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown Completed COPD 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No ate has page 2 s HIV 1□ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☑ No 1×Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred № Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident

P.O. Box 68760, Division or Vital Records, To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director,

Certification: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 18 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical

29b. Signature and title of certifier

26 2007

and manner stated. 29c. License number 29d. Date signed (Month. Day, Year)

DG-0469

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

5755 CEDAR R. YUSPIG SEREMY LANE

MD

State Registrar

			Flease	Type of Plint in			_	_	
			1 For State	State of Maryla	•	ent of Health and	Mental Hy	/giene nn 7	33488
			Registrar		Certifica	ate of Death	2. Date of D	Reg. No.	3. Time of Death
	Physici	an	Decedent's Name (First, Middle, La	(st)			Month	Day Year	
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	2		Usual Residence of Decedent	140- 0	22. T				10d. Inside City Limits
	anyla ehov	2	10a. State 10b. County	1 100.0	city, Town or Location	2			1 ✓ Yes 2 ☐ No
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N	Hygie Hygie ther		17. Father's Name (First, Middle, Last)			ame (First, Middl	e, Maiden Surname)	
an	id be ental ked c	To Be	Carl Stuin Ch	13500		Kebeca	a Reni	es Shire	maker
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Σ	and 2 Belth a m 27 to	1	Kebecca Shoen	aker/Mothe	R 8020	+ CrossC	reek D	Glent	unic, 40/2100
ore	iges 1 and 2 should be filed within 72 hours after deeth with the Marylar It of Heelth and Mental Hygiene. If Item 27 is marked other than "naturel", or Iteme 23a or 28a-f ehow or other treumatic event, It a Madical Examiner must be notified at	-	20a. Method of Disposition 1 Denial 2 Cremation 3		Place of Disposition (cometery, crematory)	or other place)	Date	20c. Location - City of	
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Baltimore	permit. Pages 1 and 3 Department of Heelth Important: If Item 27 any Injury or other tri <u>once.</u>		21. Signature of Furreral Service Lice	risee	25-25-20-12	and Address of Facility Ha			
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n	After ouners	ö	27. Manner of Death 1⊅ Natural 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work?	28d. Describe	how injury occurred	
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	To the Hospitel or Attending Ph within 24 hours eiter death. To the Funeral Director: After th completely filled in by the funeral		29a. Certifier 1 Certifying P	hysician: To the best of my kr	nowledge, death occur	ed at the time, date and place	e, and due to the	e cause(s) and manner	as stated.
	n 24 } he Fu	Medical	(Check only 2 Madical Exa	minar: On the basis of examinand manner stated.	nation and/or investigat	ion, in my opinion, death occ	curred at the time	, date and place, and de	ue to the cause(s)
	To ti Withi To ti comp	Ž	29b. Signature and title of certifier			29c. License number		29d. Date signed (Mo	nth, Day, Year)
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DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** Month 2001 /Medical Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner redical polis runde ma If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 0 Unknown Yrs. Director 200 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits NO Yes 2 No MP Director Jurnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21061 1055 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Yes 2 No Specify: ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) None None 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ၉ hivera Denee noema becca -19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) er 8024 1055 Turnic norman uot20b. Place of Disposition (Name of cemetery, crematory or other place)
Metro Crematory Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 10/2/2007 Baltimore, MD 22. Name and Address of Facility Hardesty Funeral Home, P.A. 21. Signature of Funeral Service Licensee 12 Ridgely Ave. Annapolis, MD 21401 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician 1 HR OSMIN /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dua to (or as a consequence of) Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed ettending physicien and for use as the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 menths? Month 4 ☐ Pregnant at time of death 5 Other (specify) within 24 hours after death. To the Funeral Director: After this certificate hes been signed by the e completely filled in by the funeral director, page 2 should be deteched f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 D/No 1 Tes 3 Probably 4 Unknown Completed 24a. Was an autopsy performed?
1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes No 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: ဥ 1 🗌 Yes 250 No 1 patient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 ☐ Could not be determined 28e. Ptace of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 06614 inpleted cause of death (Item 23a) (Type, Print) 30. Name and address of person who co Dr. Manie Roger's, MD 2001 Medical Parkway Annapolis, MD 21401 31. Date filed (Month, Day, Year) 32. Engistrar's Signature State OCT 0 2 2007 Registrar

DHMH 17 Rev 1/2001

Registrar
DHMH 17 Rev 1/2001

State

BARRY N. ROSENBAUM, M.D.,

2007

gistrar's Signature

3720 FARRAGUT AVE. KENSINGTON, MARYLAND

20895-2110

State of Maryland / Department of Health and Mental Hygiene Certificate of Death

Reg. No.

1. Decedent's Name (First, Middle, Last) 2. Date of Death September 30, 2007 6:25 \mathbf{P} M Josephine Reynolds Dudley 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Medical Center Anne Arundel Annapolis If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Days | Hours | Min. | (Month, Day, 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Social Security Number **Funeral** Days Year) 1 M XXF 1927 North Carolina Yrs Director **241-42-237**5 80 March 16, Usual Residence of Decedent parmit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland D-partment of Health and Mental Hygiene. Important: if item 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be maiting any of the property. 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1√XYes 2 No <u>Anne</u> <u>Ar</u>unde1 Annapolis Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21403 United States 930 Bay Forest Court Apt 224 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 □ Yes XX No If Yes, Give Year or Dates: 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 💥 🗓 No White Specity Specity: ¥ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Administrative Assistant National Publication Be (17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Joseph Revnolds Alma Alderman 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Josephine D. Moorehead / Daughter 1201 Grant Street Annapolis, Maryland 21403 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial ★☆ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Baltimore Crematory 10/2/2007 Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility John M. Taylor Funeral Home, Inc. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 147 Duke of Gloucester St. Annapolis,MD 21401 Approximate Interval Between Onset and Death **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Rin Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of): the death certificate be executed Cal that initiated events burial-tran resulting in death) Last Due to (or as a consequence of): ate has been signed by the attending physician a page 2 should be detached for use as the burial Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Day Month Year 4☐Pregnant at time of death 5 ☐ Other (specity) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1□ Yes 21/2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home Hospital: 1 Yes 2 No 3□ DOA 1 Minpatient 2 ER/Outpatient 5 ☐ Residence 6 ☐ Other (Specity) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred I or Attending F after death. 1 🗹 Natural 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 ☐ Accident Director: 3 ☐ Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specity) 28f. Location (Street and Number or Rural Route Number, City or Town, State) npletely filled in by 4 Homicide To the Hospital of within 24 hours at To the Funeral D 29a. Certifier 1 🗗 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MOORE C. (LOBERT 31. Date filed (Month, Day, Year) strar's Signature OCT 0 2 2007 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) September 30, 2007 10:35 P M CHARLOTTE М ELLIS 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Frederick Inder 1 Year | If Under 24 Hrs. | 8. Date of Birth this | Days | Hours | Min. | June 10, Frederick Memorial Hospital 5. Social Security Number 6. Sex 7. Age Frederick . Age (In yrs. last birthday) 9. Birthplace (State or Foreign Mary Tand 1 M 2 F 78 220-26-5122 Usual Residence of Decedent 10h County 10c. City, Town or Location 10d. Inside City Limits Frederick 1∰Yes 2∏No Frederick Maryland 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code U.S.A. 21701 306 East Third Street 12. Was Decedent Ever in U.S. Armed Forcee? 1 ☐ Yes 2 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. 11 Marital Status Black, White, etc. 1 Never Married 2 Married 3 Widowed 4 Divorced White 1 ☐ Yes 2 🔀 No Specify 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Lillian Fout William Kline 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 564 East Church Street, Frederick, MD 21701 19a. Informant's Name/Relationship (Type. Print) Diane Davis, Daughter Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 Cremation 3 Removal from State Resthaven Memorial Gardens Oct. 3, 2007 Frederick, MD 4 □ Donation 5 □ Other (Specify) ^{22. N}Keeney and Basford PA Funeral Home 106 East Church St., Frederick, MD 21701 of Funeral Service Lice se 21. Sign 🕅 MO0255 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Cardiac arret DAYS Due to (or as a consequence of): A cute My cardial Infalction Due to (or as a consequence of): Sequentially list conditions, it any, leading to immediate

Physician /Medical Examiner

Physician

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permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be proce-

Baltimore, Maryland 21215-0036

requires that the death certificate be executed sician and burial-trans Division or Vital Records, P.O. Box 68760 the as

Examiner Physician/Medical the a þ signed by the sign of the sign þ Completed page 2 certificate Be P this

Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a consected.		the jethy		DAYS
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome pf pregr 1 □ Live birth 2 □ Fet 4 □ Pregnant at time of 9 □ Unknown	al death 3 ☐Ectopic			23d. Date of delivery Month Day Year
Part II. Other significant conditions of	ontributing to death but not re-	sulting in the underlying	g cause given in Part I.	23e. Did tobacco u 1 ☐ Yes 2	se contribute to the cause of death? No 3 Probably 4 Unknown
				24a. Was an autopsy performed 1 Yes 2 No	24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No
25. Was case referred to medical			26. Place of De	eath (Check only one)	
examiner?	Hospital: 1 hpatient 2	☐ER/Outpatient 3☐	DOA Other: 4 Nursing	Home 5 ☐ Residence	6 □Other (Specify)
27. Manner of Death 1 □ Matural 5 □ Pending 2 □ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how injur	y occurred
3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of injury - At h building, etc. (Spec		cory, office	28f. Location (Street an City or Town, State	d Number or Rural Route Number,)
	ysician: To the best of my kn				and manner as stated. I place, and due to the cause(s)

29c. License number

DO06 2223

29d. Date signed (Month, Day, Year)

07

State Registrar

31. Date filed (Month, Day, Year) OCT 1 8 2007

30. Name and address of pason who completed

29a. Certifier (Check only one)

29b. Signature



cause of death (Item 23a) (Type, Print)

and manner stated.

within 24 hours after death. To the Funeral Director: After

To the Hospital or Attending

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Oct 13, Day 2007 Physician Early 1:45PM Bernard Maurice /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Allegany Beverly Living Center of Cumberland Cumberland If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Mar 22, Birthplace (State or Foreign Country) Social Security Number 6. Sex **Funeral** Days Hours 220-10-0670 Director 88 Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10a. State 10c. City, Town or Location show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 shov any injury or other traumatic event, the Medical Examiner must be notified at MD Allegany Cumberland 1 X Yes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21502 12603 McDonald Road, SE USA Funeral 12. Was Decedent Ever in U.S. Asped Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: WWII 14. Race - American Indian 13. Was Decedent of Hispanic Origin? (Specity Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married 1 □ Yes 2 □ No 3altimore, Maryland 21215-0036 Specify: white þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Tire Builder Kelly-Springfield Tire 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Julia E. (Kellersohn) Early Thomas F. Early ပ 19a. Informant's Name/Relationship (Type. Print)
Ruth Early Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12603 McDonald Road, Cumberland MD 21502 wife 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery crematory or other place)
Scarpelli Funeral Home, P.A Date 20c. Location - City or Town, State 10/15/2007 MD Cresaptown 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fungral Service Licensee 22. Name Scarbell Furtheral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) & lioblaste ma Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) attending physician and for use as the burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4□Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed' after death.

Director: After this certification 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 10033280 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 625 KENT AVE. CUMBERIAND, MD alson SUNIL CUPTA, M.D. 31. Date filed (Month, Day, Year) 32. egistrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 1/2001

			1 - For State Registrar	State of	f Maryland	-	artment rtificate			and M	ental Hy	/giene Reg. No	711	07	33494
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	/Medic			arles W.		Sr.					Octobe			007	5:03 P M
	Examin	er	4a. Fecility Name (If not institution, 4413 Dorado Dri		nber)				Location o			40	. County HOW	of Deeth	
	Formul				7. Age (In yrs. lasi	t birthday)	If Under		If Under:	esta .	8. Date of Bi	irth		9. Birtho	place (State or Foreign
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	s within 72 hours after death with the Maryland jiene. r than "natural", or llems 23a or 28a-1 ehow the Medical Exaciner must be medified at	Funeral	11. Marital Status	12. Was Dece	edent Ever in U.S.	13.	Was Decede	ent of His	spanic Orig	gin? (Spe	ecify Yes or N Rican, etc.)	0-		ce - Americk, White,	can Indian,
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OE	Peges nent of int: If it		1 Burial 2 □ Cremation 4 □ Donation 5 □ Other (Sp		State		natory or ottendered			0-4-	2007	Ell:	iœt	t Cit	y, MD
Baltimore,	permit. Peges Department of Important: If it any injury or one		21. Signature of Funeral Service L		M0104	4 22	2. Name and	Addres	s of Facility	Har:	ry H. V	Witz]	ce's	Fami	ily FH Inc. MD 21043
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	To the Hospitel or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune.	edical C	29a. Certifier (Check only one) 1 Certifying 2 Medical 8	Physician: To the examiner: On the ba	best of my knowle asis of examination per stated.	dge, death and/or in	occurred a vestigation,	it the tim in my op	e, date and inion, deal	d place, a	and due to the	cause(s , date an) and ma d place,	anner as s and due to	tated. o the cause(s)
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 2. Date of Death 1. Decedent's Name (First, Middle, Last) 0019 Physician Gervais auren 10 ୦ ଟି 2007 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Battimore Univ. of Maryland Med. System If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Social Security Number 6. Sex Date of Birth (Month, Day, Year) **Funeral** Days Hours **™** M 2□ F 81 June 1,1926Rhode Island Director 038-14-0440 10c. City, Town or Location 10d. Inside City Limits 10b. County show r 28a-f show notified at M∐Yes 2 No Director Woonsocket RhodeIsland Providence 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 7 is marked other than "natural", or items 23a or traumatic event, the Medical Examiner must be A. 14. Race - American Indian, U.S 36 Ridge Street 02895 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1√ Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married Yes, Give Year or Dates: WWII 1 ☐ Yes 2 XNo 3altimore, Maryland 21215-0036 SpecifyWhite Specify 2 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 72 (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Payroll Supervisor Construction permit. Pages 1 and 2 should be filed i Department of Health and Mental Hygis Important: If Item 27 is marked other i any injury or other traumatic event, tt 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Alida Bouffard Joseph M. Gervais ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Lucille J. Gervais/Wife Ridge Road, Woonsocket, Rhode Island 02895 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Bellingham, Mas ST. JohnTheBaptistCem. 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Marzullo Funeral Chapel, P.A 6009 Harford Road, Baltimore, Maryland21214 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Cardiac **Physician** Evolvina /Medical Due to (or as a consul-Examiner Block Heart Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Cardiogenic Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 2 No detached 9□Unknown 9 Unknown sate has been signed by page 2 should be detack 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1□ Yes 1 🗆 Yes the Hospital or Attending Physician: director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2□ No Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) Injury 1 □ Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No after death. 2 Accident filled in by the 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide e Funeral I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medical within 24 ho

To the Function

completely f 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 204718 200 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar eene St.

Ballmore, MD

eatt

2007

Registrar's Signature

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Physician /Medical Examiner Examiner or Attending Physician: The law requires that the death certificate be executed

Physician

Examiner

Funeral

Director

iral", or Items 23a or 28a-f show Examiner must be notified at

"natural",

Ith and Mental Hygiene.
27 is marked other than "natur traumatic event, the Medical

Department of H Important: If ite any injury or ot

Director

Completed by Funeral

Be

should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Pages 1 and 2 item 27 i

/Medical

the use as signed by the at d be detached for within 24 hours after death.

To the Funeral Director: After thi
completely filled in by the funeral or

by Physician/Medical

Be Completed

Certification: To

Medical

31. Date filed

Division or Vital Records, P.O. Box 68760,

in the past 12 n 1 ☐ Yes 2 🛣 9 ☐ Unknown			opic pregnancy ner (specify)		Month Day Year						
Part II. Other signific	cant conditions o	ontributing to death but not resulting in the under	ying cause given in Part I.	23e. Did tobi	acco use contribute to the cause of death? s 2 No 3 Probably 4 Unknown						
				24a. Was an autopsy perform 1∐ Yes 2	prior to completion of cause of death?						
25. Was case referre examiner?	ed to medical	26. Place of Death (Check only one)									
1 Yes 2 N	10	Hospital: 1 X Inpatient 2 ☐ ER/Outpatient 3	Other: 4 Nursing H	ome 5 Resider	nce 6 Other (Specify)						
27. Manner of Death 1. Natural 2 Accident	5 ☐ Pending investigation	28a. Date of Injury (Month, Day Year) 28b. Time of Injury	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how	w injury occurred						
3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e. Place of injury - At home, farm, street, building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one)	I X Certifying Ph ☑ ☐ Medical Exan	i ysician: To the best of my knowledge, death occ niner: On the basis of examination and/or investi and manner stated.	curred at the time, date and place gation, in my opinion, death occu	, and due to the ca irred at the time, da	use(s) and manner as stated. ate and place, and due to the cause(s)						
29b. Signature and t	itle of certifier		29c. License number	29	9d. Date signed (Month, Dav. Year)						

028808

400 West Seventh Street, Frederick, MD 21701

10/12/2007

3,

State Registrar

the Hospital

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

M.D.

Rusu Florin,

December Service Texas Anthony Texas A				For State Registrar	State or war yiar w		tificate of D			giene Reg. No:2 A A 7	221.07			
Part Part		Ph sist		1. Decedent's Name (First, Middle, Last,)					Death 3. Time of Death				
Entitled Part of the control of the				ROBERT			GROSS				0955 ™			
Part		Examin	er				**			4c. County of Death				
Contract Contract	1	i de La depositação de la composição de la composição de la composição de la composição de la composição de la comp							0.0					
This State 10th County 10th Street and Number 10th Street and Num		<i>\$</i>		206–14–8130	DM 2□F				(Month, Da	y, Year) C	ountry)			
18. Matther's Names (Frist, Microtine, Mandon Summers) DELLA L. STCKEL Listing (Frist, Microtine, Mandon Summers) DELLA L. STCKEL Listing (Frist, Microtine, Mandon Summers) DELLA L. STCKEL Listing (Frist, Microtine, Mandon Summers) DELLA L. STCKEL Listing (Frist, Microtine, Mandon Summers) DELLA L. STCKEL Listing (Frist, Microtine, Mandon Summers) DELLA L. STCKEL WILLIAM C. JOHNSTON / NEPHEM 150. Malling Address (Shrew and Antherise of Fruits) WILLIAM C. JOHNSTON / NEPHEM 150. Malling Address (Shrew and Antherise of Fruits) WILLIAM C. JOHNSTON / NEPHEM 150. Malling Address (Shrew and Antherise of Fruits) WILLIAM C. JOHNSTON / NEPHEM 150. Malling Address (Shrew and Antherise of Fruits) WILLIAM C. JOHNSTON / NEPHEM 150. Malling Address (Shrew and Antherise of Fruits) WILLIAM C. JOHNSTON / NEPHEM 150. Malling Address (Shrew and Antherise of Fruits) WILLIAM C. JOHNSTON / NEPHEM 150. Malling Address (Shrew and Antherise of Fruits) WILLIAM C. JOHNSTON / NEPHEM 150. Malling Address (Shrew and Antherise of Fruits) WILLIAM C. JOHNSTON / NEPHEM 150. Malling Address (Shrew and Antherise of Fruits) WILLIAM C. JOHNSTON / NEPHEM 150. Malling Address (Shrew and Antherise of Fruits) WILLIAM C. JOHNSTON / NEPHEM 150. Malling Address (Shrew and Antherise of Fruits) WILLIAM C. JOHNSTON / NEPHEM 150. Malling Address (Shrew and Antherise of Fruits) 150. Malling Address (Shrew and Antherise of Fruits) 150. Malling Address (Shrew and Antherise of Fruits) 150. Malling Address (Shrew and Antherise of Fruits) 150. Malling Address (Shrew and Antherise of Fruits) 150. Malling Address (Shrew and Antherise of Fruits) 150. Malling Address (Shrew and Antherise of Fruits) 150. Malling Address (Shrew and Antherise of Fruits) 150. Malling Address (Shrew and Antherise of Fruits) 150. Malling Address (Shrew and Antherise of Fruits) 150. Malling Address (Shrew and Antherise of Fruits) 150. Malling Address (Shrew and Antherise of Fruits) 150. Malling Address (Shrew and Antherise of Fruits) 150. Malling		land			10c. City	, Town or Loc	ation				10d. Inside City Limits			
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The part of the	7	led w lygiel her tl nt, th	S	17. Father's Name (First Middle Leat)	5+	דדד		9 Mothor's Name	/Eirot Middlo		<u> </u>			
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Physician / Modical Examiner Physic	<u>8</u>	d 2 sith an traur					-							
Physician / Modical Examiner Physic	ā,	Heal Heal tem 2 other			20b. Pl	ace of Dispos	sition (Name of	; [
Physician / Modical Examiner Physic		t. Pages tment of tant: If i		4 ☐ Donation 5 ☐ Other (Specify)	CUM	BERLAN	D CREMATO	RY 9/5/2	007	CUMBERLA	ND, MD			
Physician Modical Examiner Physician Modical Examiner Physician Security of the family interesting in death) Physician Security in death of the family interesting in the underlying cause given in Part I. 236. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 20 Month 24 Work of the family interesting in the underlying cause given in Part I. 244. Was an a specific of the family interesting in the underlying cause given in Part I. 255. Was case referred to medical warming in the underlying interesting in the underlying cause given in Part I. 256. Piace of Death 1 Yes 2 No 3 Probably 20 Month 20 Mo	סמו	permi Depar Impor any ir once.					UPCHURCH :	FUNERAL	HOME, I	P.A. ERLAND, MD	21502			
Physician Modical Examiner Due to (or as a consequence of): Due to (or as a conse				23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line.										
Due to (or as a consequence)of): Due to (or as a consequence)of):		Physician		disease or condition	15	3 husos								
Due to (or as a consequence of): Due to (or as a consequence of):		100		resulting in death)	Due to (or as a consequ	ence of):		1						
Due to (or as a consequence of): Due to (or as a consequence of):		Examiner	_	Sequentially list conditions,	b			177						
Due to (or as a consequence of): Due to (or as a consequence of):		sit s	ine	cause. Enter Underlying	Due to (or as a consequ	ence of								
Section Part 1.	3 -	ecut and I-tran	хап	that initiated events resulting in death) Last	Due to (or as a consegu	ence of):								
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Vikramad, tya Poonal M.D. 924 Seton Drive Cumberland, Mary land State 31. Date filed (Month, Day, Year) 32. Registrar's Signature	20	be e; ician buria	alE		2 40 10 (01 40 40 40 40									
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Vikramad, tya Poonal M.D. 924 Seton Drive Cumberland, Mary land State 31. Date filed (Month, Day, Year) 32. Registrar's Signature	00	icate phys s the	dic		d									
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Vikramad, tya Poonal M.D. 924 Seton Drive Cumberland, Mary land State 31. Date filed (Month, Day, Year) 32. Registrar's Signature	×	certif nding se as								23d. Date of de	elivery			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Vikramad, tya Poonal M.D. 924 Seton Drive Cumberland, Mary land State 31. Date filed (Month, Day, Year) 32. Registrar's Signature	ŏ	leath atter	ciar	in the past 12 months?							,			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Vikramad, tya Poonal M.D. 924 Seton Drive Cumberland, Mary land State 31. Date filed (Month, Day, Year) 32. Registrar's Signature	į.	t the c by the achec	hysi		9□ Unknown									
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Vikramad, tya Poonal M.D. 924 Seton Drive Cumberland, Mary land State 31. Date filed (Month, Day, Year) 32. Registrar's Signature	Ţ	s that ned t		Part II. Other significant conditions co	ntributing to death but not resu	Iting in the un	derlying cause given	in Part I.	23e. Did 1	tobacco use contribute	to the cause of death?			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Vikramad, tya Poonal M.D. 924 Seton Drive Cumberland, Mary land State 31. Date filed (Month, Day, Year) 32. Registrar's Signature	<u> </u>	quire en sig uld b	q pa						1 🗆	Yes 2□No 3□F	Probably 4 Ohknown			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Vikramad, tya Poonal M.D. 924 Seton Drive Cumberland, Mary land State 31. Date filed (Month, Day, Year) 32. Registrar's Signature	ວ	aw re s bee 2 sho	olet							an 24b. Were a	autopsy findings available			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Vikramad, tya Poonal M.D. 924 Seton Drive Cumberland, Mary land State 31. Date filed (Month, Day, Year) 32. Registrar's Signature	ב	The late ha	E o						perfe	ormed? death?	· · ·			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Vikramad, tya Poonal M.D. 924 Seton Drive Cumberland, Mary land State 31. Date filed (Month, Day, Year) 32. Registrar's Signature	<u> </u>	ian: rtifica stor, p						26. Place of Deat			3 2 3 110			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Vikramad, tya Poonal M.D. 924 Seton Drive Cumberland, Mary land State 31. Date filed (Month, Day, Year) 32. Registrar's Signature	>	nysic nis ce direc	0		Hospital: 1 ☐ Inpatient 2 ☐ €	≅R ′Outpatient	t 3 □ DOA Other:	4 ☐ Nursing Ho	me 5 ☐ Resi	dence 6 □Other (Sp	ecify)			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Vikramad, tya Poonal M.D. 924 Seton Drive Cumberland, Mary land State 31. Date filed (Month, Day, Year) 32. Registrar's Signature	S	ng Pt fter tt neral					28c. Injury a Work?	at	28d. Describe	how injury occurred				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Vikramad, tya Poonal M.D. 924 Seton Drive Cumberland, Mary land State 31. Date filed (Month, Day, Year) 32. Registrar's Signature	2	endii eath. or: A	atic	2 ☐ Accident investigation			M 1 □ Ye	s 2 No						
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Vikramad, tya Poonal M.D. 924 Seton Drive Cumberland, Mary land State 31. Date filed (Month, Day, Year) 32. Registrar's Signature	Š	or Att ter de ilrect	IĮį I		28e. Place of injury - At hor building, etc. (Specify	me, farm, stre	et, factory, office		28f. Location (City or To	Street and Number or F wn, State)	Rural Route Number,			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Vikramad, tya Poonal M.D. 924 Seton Drive Cumberland, Mary land State 31. Date filed (Month, Day, Year) 32. Registrar's Signature	ב	ital o												
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State 31. Date filed (Month, Day, Year) 32. Hegistrar's Signature		Vithi Com	Σ	29b. Signature and title of certifier						- /				
State 31. Date filed (Month, Day, Year) 32. Hegistrar's Signature				- Von	12		200	3676	6	septent.	1007			
State 31. Date filed (Month, Day, Year) 32. Hegistrar's Signature		6		30. Name and address of person who or	ompleted cause of death (Item	23a) (Type, F	Print)	h	0	,	1			
State 31. Date filed (Month, Day, Year) 32. Hegistrar's Signature				Vikramad, tya		7. 92	14 Jeton	Vrive	Cum.	berland,	Mary land			
					100	and and and and and and and and and and	1			·	•			

			For State Registrar	State o	f Maryland / Dep Ce	ertificate of			giene 0	07	334	98		
			1. Decedent's Name (First, Middle	e, Last)				2. Date of Dea Month	eath 3. Time of Death					
	Physici /Medio		James C.	Garner				Sept.	28, 2007 6:55 A					
	Examin		4a. Facility Name (If not institution	n, give street and nur	mber)	4b. City, Town, o	r Location of De	eath	4c. County	of Death				
ш		.	Potomac Valley	Nursing		Rockvi	111e		Mon	tgome	ry			
	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs. last birthday	Months Days		Irs. 8. Date of Birt In. (Month, Day	h		lace (State or	Foreign		
	Director		579-26-5886	1⊠M 2□F	96 Yrs.	Months Buys	riouis	Feb. 8			nchie,	MD		
	p _u ≥		Usual Residence of Decedent 10a, State 10b, County		10c. City. Town or I	coation				1	0d. Inside Cit	v Limite		
	anyla eho	5									1 1 Yes			
	Ne M	Director		e George's	Hyatts	ville 10f. Zip Code			10- 0'0'1	Wh-1 0-				
	with t		10e. Street and Number					10g. Citizen of		ntry ?				
	e 23	ral	2007 Wardman		edent Ever in U.S. 13	20782		(Coopin Vos or No		S .	an Indian			
	hours after death with the Maryland tursi', or items 23a or 28s-f ehow al Examiner must be notified at	Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Mar	Armed Fo	rces?	. Was Decedent of H If Yes, specify Cuba	an, Mexican, Pu	erto Rican, etc.)		ck, White,	etc.			
36	irs af	by	3 XWidowed 4 □ Divorced	1111		1 ☐ Yes 2X No	Specify:		Specia	Specify: African American				
21215-0036	d within 72 hours after death with the Marylan jene. r than "naturel", or iteme 23a or 28a-f ehow the Madical Examinet must be notified at	ed	15. Deceden	it's Education	16a. Dec	edent's Usual Occup	ation		16b. Kind of B					
7	within 72 ene. then "net he Medic	Completed	(Specify only higher Bementary/Secondary (0-12)	st grade completed) College (1	lite.	e kind of work done DO NOT use retired	during most of v d)	working						
21	d with giene. rr ther	E	4	College (/	eman			U.S. P	ostal	Servi	.ce		
P	be filed tal Hygie d other event, the	Be	17. Father's Name (First, Middle,	Last)			18. Mother's h	Name (First, Middle,	Maiden Sumar	ne)				
Maryland	D 2 2 0	To	Robert Garner			_	Edmon	ia Scott						
lan	and and m	·	19a. Informant's Name/Relations	ship (Type, Print)	19b. Mai	ling Address (Street	and Number or	Rural Route Numbe	ar, City or Town	, State, Zip	Code)			
	1 and 2 Health tem 27 I		Gerald Wells	/ Grandsor		East Morn	ingside	Dr. Atla	nta, GA	3032	24			
ore	es 1 and of Healt fitem 2 r other		20a. Method of Disposition 1 🛣 Burial 2 ☐ Cremation	3 □Removal from	State 20b. Place of Disp cemetery, cr	oosition (Name of ematory or other plac	сө)	Date	20c. Location	- City or To	own, State			
Ĕ	Pag ant: I		4 Donation 5 Other (S			erine Cem	oct.	8, 2007	McCond	chie,	MD			
Baltimore,	permit. Pages I Department of H Important: If its any injury or ot		21. Signature of Funeral Service	Licensee		22. Name and Addre	ss of Facility	McGuire F	uneral	Serv	ice, Ir	1C •		
ш	70 F 9 9		Chole Manpson 7400 Georgia Ave., N.W. Washington, D.C.											
	Physician /Medical Examiner		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between											
3			Immediate Cause (Final disease or condition	· M	ultiple				Onset and D	eath				
			resulting in death)	Due to		100 101	0 -11-02							
			Sequentially list conditions	b										
	D #	ne	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to										
	and trans	Examine	that initiated events resulting in death) Last	c.	/									
60,	requires that the death certificate be executed een signed by the ettending physicien and hould be detached for use as the buriat-transit	Ē	,	Due to	(or as a consequence of):									
8760,	cate I	dical		d.				-						
9 x	eath certific ettending p	/Me	IF FEMALE:	23c If yes out	come of pregnancy									
Box	etten for us	lan	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live b	ointh 2 ☐ Fetal death 3	☐Ectopic pregnancy	у			23d. Date of delivery Month Day Year				
o.	t the de by the tached	ysic	Physician/Me	ysic	1 Yes 2 No 9 Unknown 9 Unknown									
Δ.	that the		Part II. Other significant conditi	ons contributing to de	eath but not resulting in the	underlying cause giv	ven in Part I.	23e. Did to	obacco use con	tribute lo t	ne cause of de	ath?		
ds	sign sign	d by						101	res 2 No	3 🗌 Prob	ably 4 🗆 U	nknown		
20	v requir been si should	ete						24a. Was	on 24h	Word auto	psy findings a	walable		
Re	The law ete hes b page 2 sl	ompleted						 autop 		prior to co death?	mpletion of ca	use of		
Vital Records,		e Co	25. Was case referred to medica				-1 -1 -1	1 Yes	2 No	1 Tes	2□ No			
₹		o B	examiner?	Hoepital:	Inpatient 2 ER/Outpati	- all poor loth		Death (Check only o		/0				
o		\vdash	27. Manner of Peath		of Injury 28b. Time	of 28c. Injur	y at	28d. Describe			у/			
Division	Attending I r death. ector: After by the funer	ţ	T⊠Natural 5 Pendir 2 Accident investi	ng (Moni igation	th, Day Year) Injury	Wor	rk? Yes 2 □No							
/isi	il or Attendi efter death. I Director: A d in by the fu	flea	3 ☐ Suicide 6 ☐ Could	nined 288. Place	of Injury - At home, larm, s	treet, lactory, office		281. Location (S		ber or Rura	I Route Numb	⊃⊖ <i>r</i> ,		
ā	ellor s efte f Dir	Certification:	4 Homicide determ	buildi	ng, etc. (Specify)			City or Tou	vn, State)					
	To the Hospital or a within 24 hours efter To the Funerel Direct completely filled in b.	;al (29a. Certifier 1 Certifyin	ng Physician: To the	best of my knowledge, dea	th occurred at the tir	me, date and pla	ace, and due to the	cause(s) and m	anner as s	tated.			
	n 24 n 24 he Fu	edical	(Check only 2 Medical one)	examiner: On the b and man	asis of examination and/or ner stated.	nvestigation, in my o	opinion, death or	ccurred at the time,	date and place,	and due to	o the cause(s)			
	To the within 2 To the complet	×	29b. Signature and title of certifie	or A		29c. Licens	se number		29d. Date signe	ed (Month,	Day, Year)			
	2+1		1 price	Aller	1 M 1000	D38	3262	_	Seph	28	,200			
	(12)		30. Name and address of person	who completed caus					n	102	0850	2		
	<u> </u>		Br A MEMO	MIRAT		Reseave	L BLV	n Such	€ 330	Roc	krill	2		
	Sta		31. Date filed (Month Day, Year,	4 2007 32. F	Signature	1.5								
	Registr	ar			COUNTY SON	GOBARI								

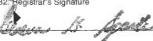
	_ For		State of Mar	yland /				Mental Hy	/gien	е	
	1 - State Registrar Certificate of Death Reg. No. 2007 3 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Tin										
Physician /Medical	1. Decedent's Nar	me (First, Middle, La	Dorothy	Lee Ga	amb1e			2. Date of Do Month Octobe	eath r 4 ^D ,	ay 2007 ^{Year}	3. Time of Death 4:00 P M
Examiner		(If not institution, gi Hospice H	ve street and number)		4	tb. City, Town, or Mt. Air	Location of Dea	th	4	c. County of Dea Frederi	
Funeral Director	5. Social Security		Sex 7. Age ('In yrs. last b 4		If Under 1 Year Months Days	If Under 24 Hrs Hours Min		rth ay, Year	9. Bir 923 Ma	thplace (State or Foreign ountry) ryland
/land ow at	Usual Residence	of Decedent 10b. County	1	0c. City, To	wn or Loca	tion					10d. Inside City Limits
a-f sh tiffied	MD	Frederi	ck	Brui	nswicl	κ					1 AYes 2 No
h with the Maryland 23a or 28a-f show st be notified at al Director	10e. Street and N 412 W	_{umber} est B Str	eet			10f. Zip Code 21716			10g. C	itizen of What Co USA	ountry?
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director		rried 2 Married 4 Divorced	12. Was Decedent Ev Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:			as Decedent of H /es, specify Cuba Yes 2 14No	ispanic Origin? (s an, Mexican, Pue Specify:	Specify Yes or N rto Rican, etc.)	0-	14. Race - Ame Black, Whit Specify: W	
ed within 72 hou ygiene. her than "natura t, the Medical E Completed		15. Decedent's E	rade completed)		(Give kil	nt's Usual Occup nd of work done of NOT use retired	during most of wo	orking	16b.	Kind of Business	/Industry
d with giene.	Etementary/Sec	condary (0-12)	College (1-4or 5+) 5		Nurse	e]]	Teacher	
ould be file Mental Hy arked othe atic event,		e (<i>First, Middle, Las</i> P. Wheat1						me (First, Middle • Shanks		en Surname)	
2 shou and N is mai	19a. Informant's	Name/Relationship	(Type. Print)			,			. ,	or Town, State,	Zip Code)
l and thealth		Pagel -	Nephew			est B St	reet - 1	Brunswic Date	,	ID 21716 Location - City or	Town State
Pages 1 tment of h tant: If ite jury or ot	4 □ Donation	2 □Cremation 3 [n 5 □ Other (Spec		ceme	etery, crema t Lawi	itory or other plac n Mem. G	ar. 10/8	3/2007	Maı	rriottsv	ille. MD eral Home
permit Depar Impor any in once.	1 Du	Funeral Service Lice	7. Willia	Gn			В	runswick	, MI		
Physician	shock, or he Immediate Cause	eart failure. List onl e (Final	mplications that caused the yone cause on each line.				ng, such as cardia				Approximate Interval Between Onset and Death
/Medical Examiner	disease or condit resulting in death		Due to (or as a							-	byears.
Je je	Sequentially list of cause. Enter Unio	conditions, immediate derlying	b. Due to (or as a	conse ¡uenc	ce of:						
ate be executed hysician and the burial-transit	Cause (Disease of that initiated ever resulting in death	or injury hts i) Last	c. Due to (or as a	consequenc	ce of):						
ate the hys			d								
The law requires that the death certific ate has been signed by the attending plage 2 should be detached for use as tompleted by Physician/Mec	IF FEMALE: 23b. Was deceded in the past 1 1 Yes 2	12 months? 2 □ No	23c. If yes, outcome pf 1 □ Live birth 2 4 □ Pregnant at tii 9 □ Unknown	Fetal dea	ath 3⊟E	ctopic pregnancy Other (specify)	,			23d. Date of de Month	slivery Day Year
hat the deby the detach	9 ☐ Unknow		contributing to death but	not resulting	a in the und	erlvina cause aiv	en in Part I.	23e. Did	tobacco	o use contribute t	o the cause of death?
w requires that the do been signed by the should be detached letted by Physic								1] Yes	2₽/No 3□P	robably 4 Unknown
rsician: The law requir s certificate has been si lirector, page 2 should Be Completed								24a. Wa auto per 1□ Yes	opsy formed?	prior to death?	utopsy findings available completion of cause of
cian; entifice ector, p	25. Was case ref	erred to medical						eath (Check only			Nacaica
	1 ☐ Yes 2[Hospital: 1 ☐ Inpatient 28a. Date of Injury		Outpatient b. Time of	3 □ DOA Oth	4 🗆 Nursing	Home 5 ☐ Res		6 Other (Spa	HOSPICE HOUSE
ing Affer	27. Manner of De 1 Natural 2 Accident 3 Suicide	5 Pending	(Month, Day	Year)	Injury		yai k? Yes 2 ☐ No				dural Route Number,
To the Hospital or Attend within 24 hours after death, To the Funeral Director; / completely filled in by the fi Medical Certificati	4 Homicide		building, etc.					City or To	òwn, Sta	ate)	
the Hospi thin 24 hou the Fune ompletely fil	29a. Certifier (Check only one)		Physician: To the best of aminer: On the basis of e and manner state	examination		estigation, in my	opinion, death oc		e, date a	and place, and du	e to the cause(s)
with Corr	29b. Signature at	nd title of certifier		, u	no	29c. Licens	e number	66	29d. E	tober S	th, Day, Year)
12	30. Name and ad	ddress of person who	-0	en 7	Drive	int) KA	UAN f	KUDHU0	5"	ND 3170	2
State	31. Date filed (M		32. Registrar	's Signature						,	
Registrar 		OCT 0 :	5 2007	W 1	B A	marke					
HIVITH IT THEY ITZUUT					ORIG	SINAL					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 8:10 A M **Physician** Charles W. Hoppert Jr. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Cumberland Allegany 14612 Moores Hollow Road 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Month, Day, Y Mar 11, Birthplace (State or Foreign Country) D 6. Sex 7. Age (In vrs. last birthday **Funeral** Hours Months Days Min 1 M 2 □ F 212-22-1929 Director 80 Usual Residence of Decedent 10c. City. Town or Location 10a State 10b County 10d. Inside City Limits works Examiner must be notified at Cumberland MD Allegany 1 ¥Yes 2 No Director 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21502 USA 14612 Moores Hollow Road items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 DYes 2 DNo If Yes, Give Year or Dates: WWII 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 72 hours after 1 Never Married 2 Married 1 □ Yes 2 □ No Saltimore, Maryland 21215-0036 'natural", or ş Specify: white 3 ☐ Widowed 4 ☐ Divorced Completed the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) than, Elementary/Secondary (0-12) College (1-4or 5+) s 1 and 2 should be filed within Health and Mental Hygiene. Item 27 Is marked other than Baltimore Fire Dept. Fireman 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Charles W. Hoppert, Sr. Grace Cook Hoppert 2 19a. Informant's Name/Relationship (Type. Print) Jessie Hoppert 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zin Code) 14612 Moores Hollow Cumberland MD 21502 wife permit. Pages 1 a Department of Hes Important: If item any injury or othe 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Scarpelli Funeral Home, P.A. 10/10/2007 MD Cresaptown 4 ☐ Donation 3 ☐ Other (Specify) 21. Sign were of Funeral Service Lions 22. Name Scarbelli Finieral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 231 Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, spock, or heart failure. List only one cause on each line. Imm. flate Cause (Final distriction condition resulting in death) a. Adenocurcinoma of Colon Approximate Interval Between Onset and Death **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to infine list cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of): the buriai-Box 68760 the attending physician Physician/Medical as 1 use a IF FEMALE 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 □ Ectopic pregnancy jo Month Year Day 5 Other (specify) P.O. 1 ☐ Yes 2 ☐ No detached 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, pe 1 Tes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ► No 24a. Was an has je 2 autopsy performed page this certificate 2KNo Physician: director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner' Other: 4 Nursing Home 5 AResidence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 2 funeral 28b. Time of 27. Manner of Death 28a. Date of Injury 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending Is within 24 hours after death. To the Funeral Director: After Certification; 5 Pending investigation (Month, Day Year) Injury 1 Natural 1 □ Yes 2 □ No 2 Accident the 6 Could not be determined 28e. Place of injury · At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide in by t 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide completely filled 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) Medi 29d. Date signed (Month, Day, Year) October 10, 2007 29b. Signature and title of certifier 29c. License number 30 Name and address of person who completed pause of death (Item 23a) (Type, Print) Paul Taylor Livengood MD 912 Seton Drive Cumberland Maryland 21502

Paul Taylor Livengcod MD 31. Date filed (Month, Day, Year)

32. Begistrar's Signature

Registrar



DHMH 17 Rev 1/2001